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ABSTRACT

Prepared annually, the Hawaii State Plan is a public document for guiding the development of services and facilities for the mentally retarded. Using quantitative and narrative information it describes present services, presents a program for development of facilities to meet needs, and serves as the basis for allocation of funds under P. L. 88-164. Chapter 1 covers purpose, authority, organization of Health Department, the State Advisory Council, and goals of the plan. Demographic, geographic, and political characteristics of Hawaii are summarized in Chapter 2. Discussed next are public interest in mental retardation, the planning concept, factors influencing planning, characteristics of the retarded, scope of the problem, range of services, and relationship to other planning efforts. Chapter 4 states planning considerations unique to Hawaii, delineates planning areas, and examines percentage of retarded and special education classes and generic services provided. Chapter 5 contains an inventory and analysis of existing facilities and services and a review of programed facilities and priorities. Information on methods of administration, revised laws of Hawaii, and several special projects is appended. (KW)

ED054553

FACILITIES FOR THE MENTALLY RETARDED

Chance for Useful Work

Measles Resurgence
Sparks New Campaign
To Immunize Children

Wasted People

Mentally Retarded Could
Fill Many Job Openings

New Program
For Retarded
Children Here

Retarded to Come Home

Volunteer students
aid the retarded

Local care urged

New Child Aid Center

HAWAII STATE PLAN
STATE DEPARTMENT OF HEALTH
HOSPITAL AND MEDICAL FACILITIES BRANCH
1970

EC033196E

Hawaii State Plan

Facilities
FOR THE
Mentally Retarded

U.S. DEPARTMENT OF HEALTH, EDUCATION
& WELFARE
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FISCAL YEARS 1970 AND 1971

Honolulu, Hawaii
October, 1970

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CHAPTER I

. . . PURPOSE

. . . AUTHORITY

. . . ORGANIZATION OF HEALTH DEPARTMENT

. . . STATE ADVISORY COUNCIL

. . . GOALS OF THE STATE PLAN

FUNCTIONS OF THE STATE PLAN

The Hawaii State Plan, Facilities for the Mentally Retarded, prepared annually, is a public document for guiding and influencing the development of services and facilities for the mentally retarded. It describes the present pattern of services and facilities throughout the State and presents a comprehensive program for the development of needed facilities designed to provide quality treatment and care of the retarded. The Plan serves as the basis for allocation of funds available under provisions of Title I, Part C of P. L. 88-164* and aids in evaluating the need for construction contemplated outside the Federal program.

The State Plan is submitted in accordance with legislative requirements and regulations and contains quantitative and narrative information to assist in planning. Inventories of the original Plan are up-dated, the narratives modified, and the data recorded in greater detail in this annual revision.

AUTHORITY

By an act of the Hawaii legislature approved April 20, 1964 the Department of Health was designated as the sole agency for implementing the Mental Retardation Facilities Construction Act of 1963. The Federal act as it appears in Chapter 48-A of the Revised Laws of Hawaii as amended to include "this or any other act of Congress existing or hereafter enacted which relates to the planning, survey and construction of hospitals and medical facilities and other facilities related to each." (See Appendix, page 83.)

The Hawaii State Director of Health has designated the Chief of the Hospital and Medical Facilities Branch as the director and coordinator of the following construction programs:

1. Facilities for the Mentally Retarded
2. Community Mental Health Centers
3. Hospitals and Medical Facilities

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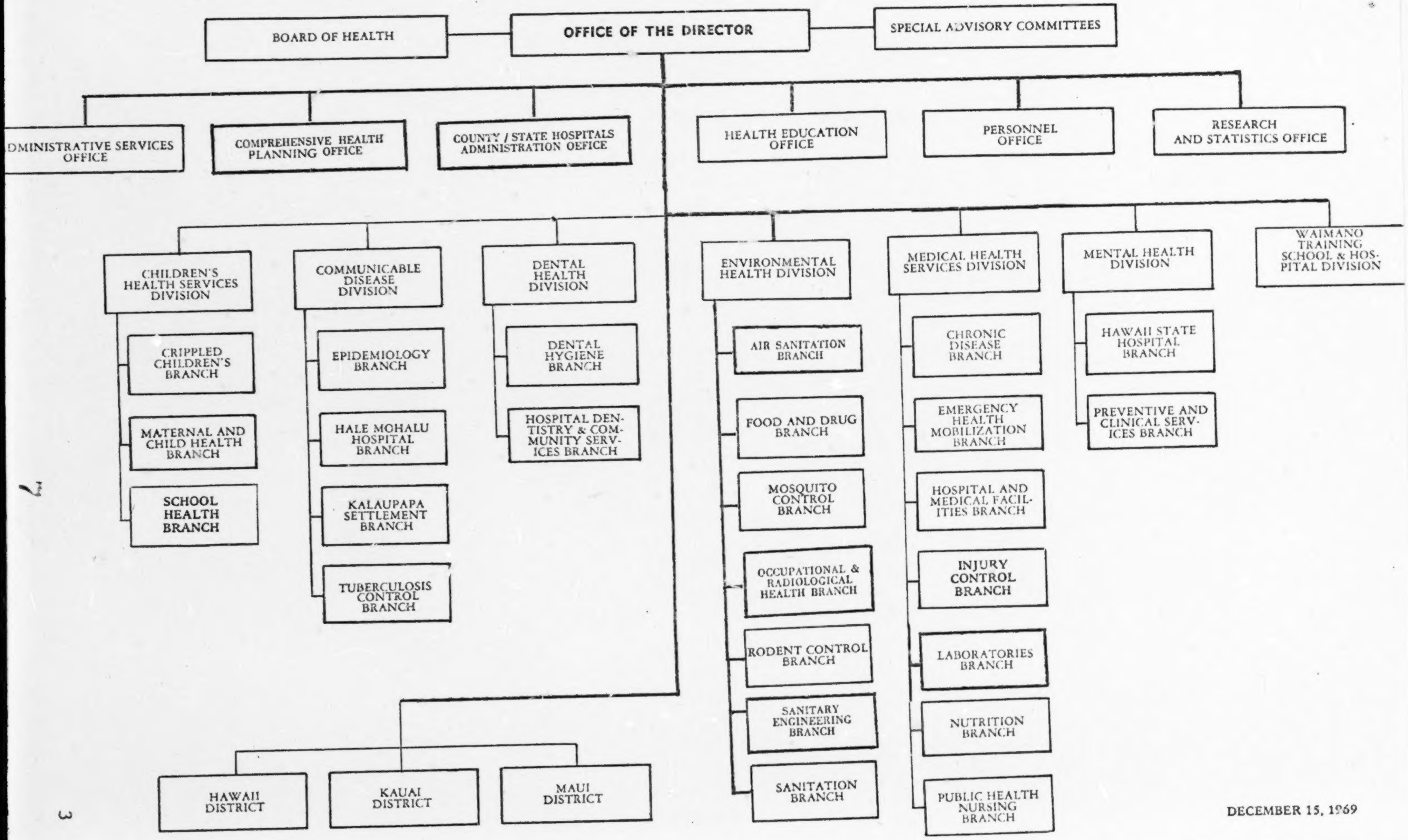
*The Mental Retardation Facilities and Community Mental Health Centers Construction Act of 1963.

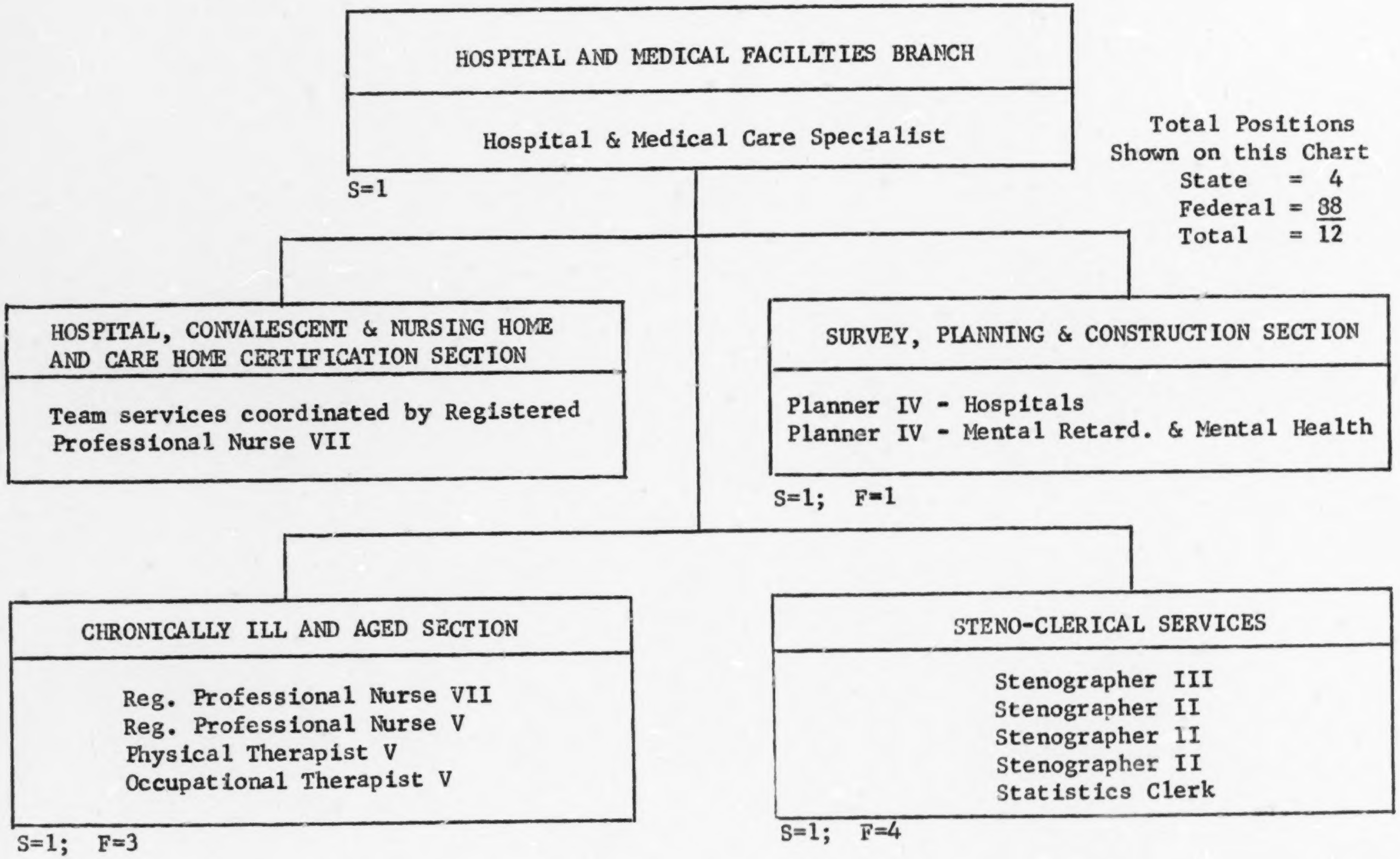
STATE OF HAWAII
DEPARTMENT OF HEALTH

ORGANIZATION CHART


BOARD OF HEALTH
OFFICE OF THE DIRECTOR
SPECIAL ADVISORY COMMITTEES
DMINISTRATIVE SERVICES OFFICE
COMPREHENSIVE HEALTH PLANNING OFFICE
COUNTY / STATE HOSPITALS ADMINISTRATION OEFICE
HEALTH EDUCATION OFFICE
PERSONNEL OFFICE
RESEARCH AND STATISTICS OFFICE
CHILDREN'S HEALTH SERVICES DIVISION
CRIPPLED CHILDREN'S BRANCH
MATERNAL AND CHILD HEALTH BRANCH
SCHOOL HEALTH BRANCH
COMMUNICABLE DISEASE DIVISION
EPIDEMIOLOGY BRANCH
HALE MOHALU HOSPITAL BRANCH
KALAUPAPA SETTLEMENT BRANCH
TUBERCULOSIS CONTROL BRANCH
DENTAL HEALTH DIVISION
DENTAL HYGIENE BRANCH
HOSPITAL DENTISTRY & COMMUNITY SERVICES BRANCH
ENVIRONMENTAL HEALTH DIVISION
AIR SANITATION BRANCH
FOOD AND DRUG BRANCH
MOSQUITO CONTROL BRANCH
OCCUPATIONAL & RADIOLOGICAL HEALTH BRANCH
RODENT CONTROL BRANCH
SANITARY ENGINEERING BRANCH
SANITATION BRANCH
MEDICAL HEALTH SERVICES DIVISION
CHRONIC DISEASE BRANCH
EMERGENCY HEALTH MOBILIZATION BRANCH
HOSPITAL AND MEDICAL FACILITIES BRANCH
INJURY CONTROL BRANCH
LABORATORIES BRANCH
NUTRITION BRANCH
PUBLIC HEALTH NURSING BRANCH
MENTAL HEALTH DIVISION
HAWAII STATE HOSPITAL BRANCH
PREVENTIVE AND CLINICAL SERVICES BRANCH
WAIMANO TRAINING SCHOOL & HOSPITAL DIVISION
HAWAII DISTRICT
KAUAI DISTRICT
MAUI DISTRICT

DECEMBER 15, 1969

DEPARTMENT OF HEALTH
MEDICAL HEALTH SERVICES DIVISION
HOSPITAL AND MEDICAL FACILITIES BRANCH
Organization Chart


HOSPITAL AND MEDICAL FACILITIES BRANCH
Hospital & Medical Care Specialist
S=1
HOSPITAL, CONVALESCENT & NURSING HOME AND CARE HOME CERTIFICATION SECTION
Team services coordinated by Registered Professional Nurse VII
SURVEY, PLANNING & CONSTRUCTION SECTION
Planner IV - Hospitals
Planner IV - Mental Retard. & Mental Health
S=1; F=1
CHRONICALLY ILL AND AGED SECTION
Reg. Professional Nurse VII
Reg. Professional Nurse V
Physical Therapist V
Occupational Therapist V
S=1; F=3
STENO-CLERICAL SERVICES
Stenographer III
Stenographer II
Stenographer II
Stenographer II
Statistics Clerk
S=1; F=4

Total Positions
Shown on this Chart
State = 4
Federal = 88
Total = 12

The Department of Health administers all State public health programs as shown in the organizational chart (see page 3), including the coordinating of mental retardation planning and implementation through the Governor's committee and its project staff.

STATE ADVISORY COUNCIL

Appointed by the Governor, John A. Burns, on June 3, 1965, the State Advisory Council serves the Director of the State Department of Health, advising him on matters pertaining to the State construction plans for mental health centers, facilities for the mentally retarded and for hospitals and medical facilities, as well as matters relating to allocation of funds for these purposes.

The appointed council represents health, welfare and education agencies, labor unions, churches, professionals and businessmen, and a representative from each of the three neighbor counties excluding Kalawao, which is under the control of the State Health Department. Representation of this advisory council meets the requirements of Public Law 88-164. Its composition includes the following appointees who serve "at the pleasure of the Governor" for indefinite terms:

Consumers:

Right Reverend Harry S. Kennedy, D.D., S.T.D.
Retired Episcopal Bishop - Oahu
1001 Wilder Avenue, Honolulu, Hawaii 96822

Philip T. Chun
Attorney - Oahu
257 Alexander Young Building, Honolulu, Hawaii 96813

Barry Chung
Prosecuting Attorney, City & County of Honolulu - Oahu
3229 Huelani Drive, Honolulu, Hawaii 96822

Gordon I. Tanioka
Insurance Executive - Oahu
2904 Oahu Avenue, Honolulu, Hawaii 96822

Hiroshi Minami
Executive Director, Health & Community Services Council of Hawaii - Oahu
2510 Myrtle Street, Honolulu, Hawaii 96816

Gerald F. Payne
Vice President, Hawaiian Telephone Company - Oahu
55 Akilolo Street, Honolulu, Hawaii 96821

Consumers - continued

Reverend Edwin J. Duffy
Pastor, St. Pius X Church - Oahu
2949 Kahawai Street, Honolulu, Hawaii 96822

Christian Nakama
Executive Secretary, Honolulu Committee on Aging - Oahu
2033 Makiki Street, Honolulu, Hawaii 96822

Tyson Benson
Electrical Engineer - Maui
Kihei, Maui

Angela Russell
Director, Brantley Center - Hawaii
P. O. Box 407, Honokaa, Hawaii 96727

Mary Apffel
Project Coordinator, Hawaii Association for Retarded Children - Oahu
3674 Hilo Place, Honolulu, Hawaii 96816

Government:

Tom T. Ebesu
Administrator, Hawaii Public Employees Health Fund - Oahu
Department of Budget and Finance, State Capitol, Honolulu

Kuniji Sagara
Administrator, Vocational Rehabilitation and Services for the Blind Division - Oahu
Department of Social Services, P. O. Box 339, Honolulu

Royce E. Higa (resigned July 28, 1970)
Deputy Director, Department of Social Services - Oahu
P. O. Box 339, Honolulu, Hawaii 96809

Fusao Uchiyama
Special Education Curriculum Specialist, Department of Education - Oahu

Non-Government:

Kenji Goto (Vice Chairman)
Hospital Consultant - Oahu
99-869 Lalawai Drive, Aiea, Hawaii 96701

Theodore Tomita, M.D.
General Practitioner - Oahu
633 No. Judd Street, Honolulu, Hawaii 96817

Non-Government - continued

Richard K. C. Lee, M.D.
Medical Coordinator, Community Medicine, Straub Clinic - Oahu
888 So. King Street, Honolulu, Hawaii 96813

Toru Nishigaya, M.D. (Chairman)
General Practitioner - Oahu
Room 202, 3538 Waialae Avenue, Honolulu, Hawaii 96816

Eddie E. Lapa
Insurance Service, I.L.W.U. - Oahu
451 Atkinson Drive, Honolulu, Hawaii 96814

Philip Coke
Administrator, G. N. Wilcox Memorial Hospital - Kauai
3420 Kuhio Highway, Lihue, Kauai 96766

The State Advisory Council, with its members representing the medical, mental health, mental retardation and related fields, reviews construction plans and applications for federal funding among its advisory duties. The Council assists in the coordination of facilities planning, the efficient utilization of existing facilities and services, and in the prevention of unnecessary overlapping or duplication of services.

GOALS OF THE STATE PLAN

1. To reach all mentally retarded individuals with services instrumental in their personal growth and betterment.
2. To inventory the needs of the mentally retarded in terms of services in all Planning Areas throughout the State of Hawaii.
3. To evaluate these needs and determine to what extent they may be fulfilled by existing facilities or may require new construction.
4. To program future construction justified by above data.
5. To coordinate planning with public or private agencies involved in programs for the mentally retarded.

Recent Federal M.R. Construction Grants in Hawaii

M.R. Project	Proj. No.	Category	Total Cost	Fed. Share
Ho'opono Annex	48	Mental Retard. & Rehab.	$ 943,243.00	$188,012.84
Waimano Trng. Sch. & Hosp.	53	Mental Retard.	1,695,000.00	287,080.00*
Brantley Center	57	Mental Retard.	253,232.00	81,052.00
J. Walter Cameron Center	58	Mental Retard.	1,902,062.59	131,868.00*

*Includes 1970 grant requests.

Methods of Administration

There are no changes in this edition pertaining to methods of administration of the mental retardation construction program under Title 1, Part C, P.L. 88-164, as amended. The Appendix (beginning on page 76) describes in detail these administrative procedures.

CHAPTER II

. . . GENERAL CHARACTERISTICS OF THE STATE OF HAWAII

. . . GOVERNMENT

. . . POPULATION AND ECONOMY

GENERAL CHARACTERISTICS OF THE STATE OF HAWAII*

Although the Hawaiian archipelago consists of many islets, reefs and shoals strung out from northwest to southeast for 1,600 statute miles in the north central Pacific Ocean, the State of Hawaii is a group of seven inhabited islands and one uninhabited island. Honolulu, capital and chief population center of Hawaii, is 2,406 miles from San Francisco and 3,906 miles from Yokohama.

All of the major Hawaiian Islands are of volcanic origin and mountainous with elevations as high as 13,784 feet. Much of the surface is rugged with high ranges marked by deeply eroded ravines and gorges. Coastal plains, valley floors and certain accessible plateaus hold the agricultural lands and the urbanizing areas.

Hawaii has a warm moderate climate with great local variations in rainfall. In Honolulu, 12 feet above sea level on the leeward side of Oahu, the lowest temperature on record is 57°F, the highest 93°F, with an average rainfall of 24 inches. The greatest recorded temperature range (52°F to 98°F) was at Mahukona, near the northern tip of the Island of Hawaii. Annual rainfall averages 139 inches in Hilo, Hawaii; 6.5 inches at Kawaihae, Hawaii and 461 inches on Mt. Waialeale, Kauai. Snow often caps the volcanic peaks of Mauna Kea and Mauna Loa, on the Island of Hawaii and Haleakala on the Island of Maui.

GOVERNMENTAL STRUCTURE**

The government in the State of Hawaii is limited to State and County levels. There are no municipal or school political subdivisions. Under the elected Governor and Lt. Governor the administration of the State is carried out in a centralized structure of only 17 departments. A bicameral legislative body convenes annually under the State Constitution, adopted on Hawaii's admission as a State.

Hawaii's local government structure is unique in its simplicity. Four political subdivisions provide all the local

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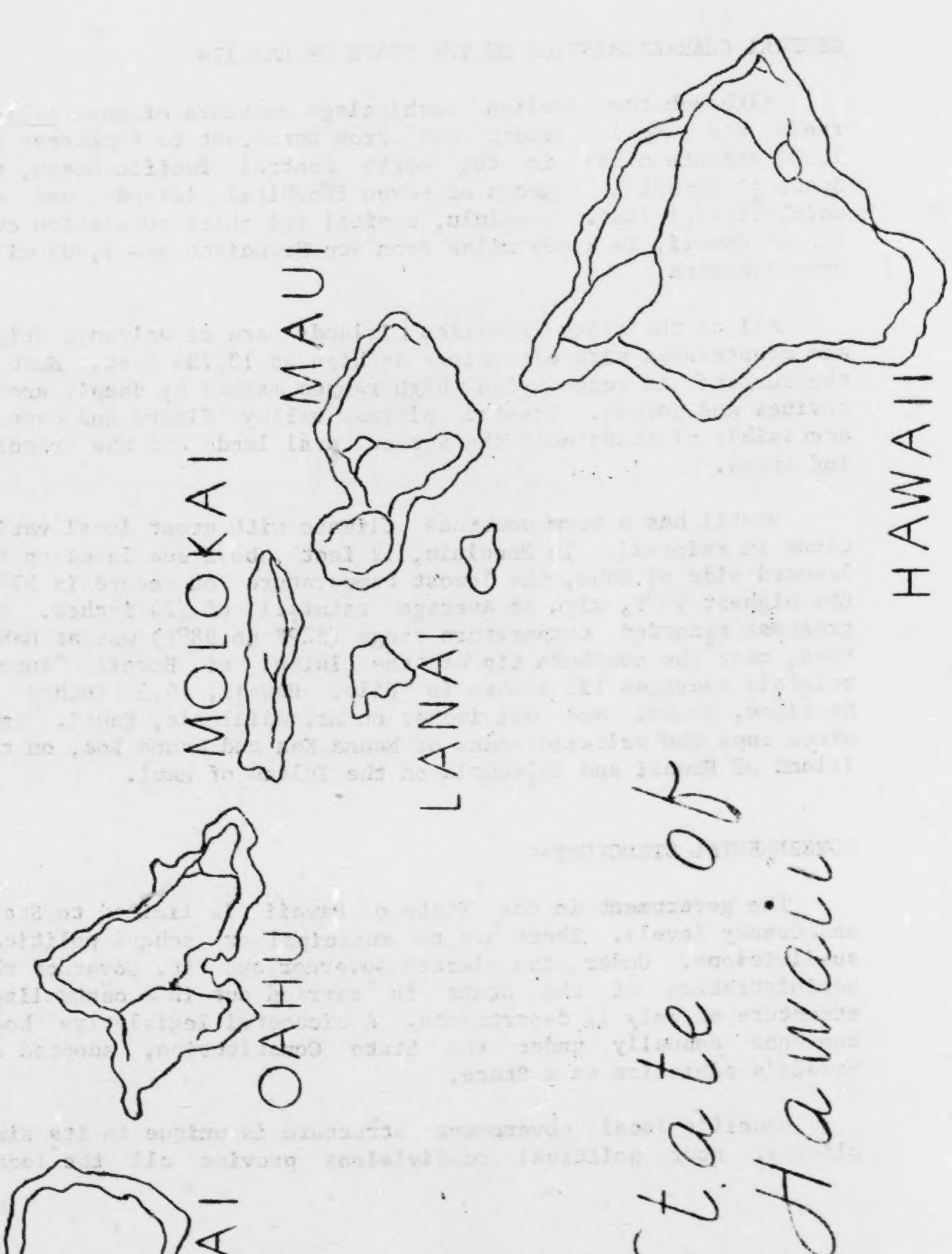
*Source: The General Plan of the State of Hawaii
**Source: Guide to Hawaii State Government


State of Hawaii
KAUAI
OAHU
MOLOKAI
LANAI
MAUI
HAWAII
Not to Scale
North

governmental services delegated by the State. Although the units of local government in Hawaii are designated and known as "counties" and possess forms and structures generally analogous to the prevailing mainland patterns, they are not generally comparable to the traditional mainland county. Many of the functions which are traditionally performed by mainland counties as agents of the State are performed directly by the State of Hawaii, such as the administration of circuit courts, assessment of property for taxation, administration of public health and public welfare provision and supervision of local schools. The counties in Hawaii, however, perform most services which on the mainland are traditionally assigned to cities, towns and villages. These include fire and police protection, refuse collection, construction and maintenance of streets and other public works and street lighting.

The four major counties in the State of Hawaii are Kauai, Maui, Hawaii, and the City and County of Honolulu. Each county consists of from one to three populated islands separated by international waters. Hawaii County comprises the entire Island of Hawaii; Maui County--the Islands of Maui, Molokai and Lanai; Kauai County--the Islands of Kauai and Niihau; City-County of Honolulu--the Island of Oahu.

Each county includes urban areas, agricultural lands and extensive undeveloped areas. Kauai, Maui and Hawaii are primarily rural counties and are similar in governmental structure and function.

The legislative body in each county is an elected Board of Supervisors whose chief Executive Officer is elected as County Chairman. The City and County of Honolulu, because of its urban character, has a number of distinctive and complex features which are not found in the other counties. It is organized under the mayor-council form of government with the mayor acting as the executive branch and the ninemember council as the legislative branch.

Traditionally, Hawaii has had a highly centralized form of governmental structure. The public health, welfare, education services, the judiciary, taxation functions are provided by the State Government, organized and administered on the county basis. The Department of Health, the State public health agency; the Department of Social Services, the State public welfare agency; and the Department of Education, the State public school agency; administer their respective programs and services throughout the State, which has been subdivided and organized on the political-county basis.

Besides the four counties mentioned, there is one other county known as Kalawao which is administered directly under the State Department of Health. Consisting of a small lava reef off the northeast coast of Molokai, this county houses only the leprosarium and staff needed to care for the patients.

POPULATION AND ECONOMY

In 1968, the State of Hawaii had an estimated civilian population of 727,000*. Before World War II Hawaii's economy was based on agriculture. Employment, production, and income were dependent on the sugar and pineapple industries. Although these economic sectors have not declined they are no longer the greatest contributors to Hawaii's economic base.

The past two decades have witnessed a remarkable gain in the visitor industry and its related businesses, as well as an increase in goods and services for the armed forces and their families. The value of these goods and services substantially exceeds the value of all commodity exports.

Several leading factors have benefited Hawaii's growth:

1. Geographically, Hawaii's location has made it one of the world's travel centers, a center for American defense throughout the Pacific and a nucleus for services to the entire Pacific region.
2. A climate which enables a continuous growing season for agricultural produce.
3. Business and political relations with other states and with the Federal Government have made growth possible in trade and in economic specialization.

The State of Hawaii has an exceptionally youthful population with over one half of its people under 24 years of age. The national median in 1960 was 30 years. Based on the ratio of the county's population each county has a similar proportion of youths, however, Hawaii, Kauai and Maui have a greater proportion of population over 65 years of age.

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*Provisional estimate of U.S. Bureau of Census, Series P-25, No. 414, dated January 28, 1969.

Honolulu, the State's Capitol, is the major transportation center and the urban heart of the State. The City and County of Honolulu (the Island of Oahu) has nearly 80% of Hawaii's population, employment and income, but less than 10% of the State's land. Its economic growth has never been more rapid than at present.

The ever-increasing freeway system has encouraged development of business and office buildings and fuller utilization of land uses near its planned centers.

The Neighbor Islands have experienced some growth in recent years--reversing a thirty year downtrend in population and employment. Such declines are commonly felt in agricultural areas everywhere when the young people reach employable age and migrate to urban centers to find jobs. Rises in income and standards of living have accelerated recently with a significant effect on retailing services and construction. Stimulus from the visitor industry has strengthened the Neighbor Islands' economic growth, by creating employment opportunities in the new hotels and related services.

The Island of Hawaii (map on page 30) produces the most sugar, has the highest mountains and the largest ranch area in the State. Sugar acreage has been increasing as well as the yield per acre due to more efficient techniques.

Maui County which includes three inhabited Islands, Maui, Molokai and Lanai, (map on page 31) is currently growing rapidly with the increased tourist activity. The Kaanapali-Lahaina area has become a major tourist area since 1965.

Kauai (map on page 33) has had less growth in population and employment recently due to the decline in pineapple and sugar employment, which has not yet been balanced by growth in tourism.

Hawaii State Data Summary by Counties

	Hawaii	Maui	Honolulu	Kauai	State Total
Area (sq. mi.)	4,021	1,159*	605	625	6,424
Housing Units	20,371	15,284	172,917	9,676	218,248
Labor Force (3/69)	26,500	19,350	252,350	13,100	311,300
Unemployment Rate	3.4	3.4	2.4	3.0	2.6
Sugar Prod.**	$65.6M	$40.0M	$30.2M	$39.2M	$175.0M
Pineapple Prod.**	None	$45.5M	$83.4M	$ 4.3M	$133.2M
Diversified Agriculture**	$17.7M	$ 5.8M	$23.6M	$ 2.9M	$ 50.0M
Tourist Expenditures**	$26.2M	$28.1M	$320.0M	$25.7M	$400.0M
Visitors	247,555	263,035	1,001,810	237,985	1,001,810
Hotel Rooms	2,222	2,241***	14,583	1,558	20,604
Telephones	25,455	18,320	268,190	11,884	323,849
Retail Sales**	$81.0M	$61.9M	$1,217.1M	$34.4M	$1,394.4M
Construction	$15.8M	$11.8M	$ 334.5M	$ 4.8M	$ 366.9M
Assessed Value Real Prop.** (1965)	$254.9M	$215.7M	$3,996.5M	$106.9M	$4,574.0M

---

* County total does not include 14 square miles for Kalawao County which is part of Molokai Island.

** Million dollars.

*** Maui County hotel rooms include 123 rooms on Molokai and 10 rooms on Lanai Island.

Labor Force and Employment figures from Department of Labor and Industrial Relations.

Hotel rooms and visitor information from Hawaii Visitors Bureau.

Other data from "Hawaii '68" Annual Economic Review, Bank of Hawaii, August, 1968.

CHAPTER III

. . . PUBLIC INTEREST IN MENTAL RETARDATION

. . . THE PLANNING CONCEPT

. . . FACTORS INFLUENCING PLANNING

. . . CHARACTERISTICS OF THE MENTALLY RETARDED

. . . SCOPE OF THE PROBLEM

. . . RANGE OF SERVICES

. . . RELATIONSHIP TO OTHER PLANNING EFFORTS

PUBLIC INTEREST IN MENTAL RETARDATION

In 1950 public interest in the problem of mental retardation was so slight that it had no place on the agenda at the White House Conference on Children and Youth. However, in 1960, it ranked as the third most important topic for discussion on the White House Conference agenda*.

Since that time there has been a growing awareness of the need for programs to serve the mentally retarded. A sense of urgency accompanies the firm determination to provide appropriate services for all levels of retardation in all age groups. The need is apparent for effective, realistic and practical planning for facilities in a more balanced pattern of distribution covering a wider geographic area.

THE PLANNING CONCEPT

The prime objective of all programs for the mentally retarded is to provide opportunities for each individual to reach his fullest potential. During the planning of services and facilities, recognition of this objective calls for specific goals for each individual and each program. Periodic reassessment of program objectives in terms of individual potentials is necessary along with a built-in flexibility within programs to permit quick and easy adaption to changing requirements.

In the light of the objectives described, planning should involve utilization of community services insofar as feasible and practical. The values accruing to the individual and the family make it desirable to encourage the inclusion of the retarded within the framework of community programs. The effectiveness of these programs will depend upon the degree of understanding of the special needs of the retarded and the consideration given to these special needs by personnel administering the programs to the extent appropriate and practicable.

Services and facilities should be planned for availability within the community. This permits utilization of the family and community resources, helps sustain family interest in the individual and facilitates assimilation of the retarded into the normal patterns of community life. Effective planning for the retarded within this community orientation calls for correlation with other community planning activities in the areas of health, education and welfare to assure full utilization of the available resources and to avoid duplication wherever possible.

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*Reader's Digest, September 1960.

Those planning for the mentally retarded must bear in mind that not all new services or expansion of existing services will require added facilities. Frequently additional programs can be held within the facilities currently in operation. Efficient planning entails careful analysis of the potentials of the existing facilities to provide adequate functional space for new programs to be developed.

A comprehensive attack on mental retardation should include preventive services as well as care and treatment services. Prevention is the most effective means of reducing the prevalence of mental retardation. A significant proportion of these handicapping conditions results from conditions which are preventable. Full application and utilization of existing knowledge to correct adverse community conditions, combined with specific preventive measures, would eliminate many new cases of mental retardation.

During the planning process, it must be recognized that mental retardation and mental illness are separate and distinctive problems. The two problems are related in that they may occur in the same patient and may involve some of the same kinds of professional skill in diagnosis and in the care of the individual involved. However, there are basic differences between them which require different concepts and objectives in the planning and treatment process. Planning in both areas should be correlated to the fullest extent possible to insure maximum use of available resources.

Effective planning includes the realistic assessment of mental retardation needs and an analysis of these needs in terms of services and facilities required. All existing programs and structures must be evaluated and their capacities and potentials determined. Additional services and facilities, which are needed must be recommended and action programed.

The understanding, support, and leadership of professional groups already involved in the field of mental retardation can stimulate the interest of participants from other walks of life in the community.

FACTORS INFLUENCING PLANNING

The planning of services and facilities for the mentally retarded is affected by many factors. The larger number of retardates in areas of low income and high population density suggests a greater prospective need for services where cultural deprivation is apparent.

The types of planning required are influenced by the number of individuals in each of the classified levels of retardation (mild, moderate, severe, and profound) as well as by the number in each age group (pre-school children, school age children, and adults). A concentrated survey of existing services and facilities must be made to determine what portions of present demands already are being met.

Availability of community services to the mentally retarded must be considered, as most planning areas have some generic services open to this group. Effective and realistic planning requires thorough knowledge of these other community programs and their potential for the growth and betterment of our retarded. Specialized services and facilities capable of maintaining quality programs require public understanding and backing such as that accorded generic services.

Significant planning problems arise in bringing services and clientele together. The availability of services and facilities does not necessarily imply adequate utilization. In many cases it is difficult to avoid duplication and overlapping.

Standards for programing have not been developed to insure adequate services for some levels of retardation or age grouping. Refined techniques are not yet available for estimating numbers of retardates and for evaluating demographic cultural and economic changes. Development of these techniques would benefit in determining to what extent any facility is actually fulfilling the needs of the area as well as its flexibility to meet a variety of changes.

Adding to these problems are the shortages of qualified personnel, limited financial support, and incomplete understanding and acceptance of mental retardation as a community problem.

CHARACTERISTICS OF THE MENTALLY RETARDED

Mental retardation--like being nearsighted or hard of hearing--is a condition. It's not a disease and is not always readily detected. The mental development is impaired or incomplete.

Retardates learn more slowly and have less capacity for

DEVELOPMENTAL CHARACTERISTICS OF THE MENTALLY RETARDED

Degrees of Mental Retardation	PRE-SCHOOL AGE 0-5 Maturation & Development	SCHOOL AGE 6-20 Training & Education	ADULT 21 and over Social & Vocational Adequacy
MILD	Can develop social and communication skills, minimal retardation in sensorimotor areas; often not distinguished from normal until later age.	Can learn academic skills up to approximately sixth grade level by late teens. Can be guided toward social conformity.	Can usually achieve social and vocational skills adequate to minimum self-support but may need guidance and assistance when under social or economic stress.
MODERATE	Can talk or learn to communicate; poor social awareness; fair motor development; profits from training in self-help; can be managed with moderate supervision.	Can profit from training in social and occupational skills; unlikely to progress beyond second grade level in academic subjects; may learn to travel alone in familiar places.	May achieve self-maintenance in unskilled or semi-skilled work under sheltered conditions; needs supervision and guidance when under mild social or economic stress.
SEVERE	Poor motor development; speech is minimal; generally unable to profit from training in self-help; little or no communication skills.	Can talk or learn to communicate; can be trained in elemental health habits; profits from systematic habit training.	May contribute partially to self-maintenance under complete supervision; can develop self-protection skills to a minimal useful level in controlled environment.
PROFOUND	Gross retardation; minimal capacity for functioning in sensorimotor areas; needs nursing care.	Some motor development present; may respond to minimal or limited training in self-help.	Some motor and speech development; may achieve very limited self-care; needs nursing care.

Source: U. S. Dept. of Health, Education & Welfare. Mental Retardation Activities of the U. S. Dept. of Health, Education, & Welfare. Washington, D.C., U. S. Government Printing Office, July 1963, p. 2.

reasoning than average children. Even after slow response in making a decision, poor judgment may result.

Mental retardation is a syndrome which can be produced by many positive agents acting singularly or in combination. Symptomatically it is characterized by subnormal intellectual function, preventing the person from responding efficiently to the usual learning process.

From a social standpoint the retarded child is slower in maturing and acquiring social and practical skills. As an adult the retardate has less than the normal expected ability to manage his affairs and to progress in gainful employment. The currently accepted definition of mental retardation by the American Association of Mental Deficiency is "Sub-average general intellectual functioning which originates during the developmental period and is associated with impairment of adaptive behavior." "Mental Retardation" thus encompasses a wide range of variance from minimal to profound. The distinction between normality and the mildest degree of mental retardation is arbitrarily defined (see Developmental Characteristics, page 20.)

Generally speaking categories of service are established according to the practical level of functioning and age rather than the cause of retardation. Nevertheless etiology may have to be considered in the specifics of treatment or education for particular individuals. Practical distinctions must therefore be based on extent of impairment taking into account the various factors which contribute to intellectual and social functioning. The manifestation of these levels of function changes with age.

SCOPE OF THE PROBLEM

As previously stated, retardates have an impairment of ability to learn and to adopt to the demands of society. These demands are not the same in every culture; even within our own society they vary with the age of the individual. Society as a whole does little to assess the intellectual or social accomplishments of the pre-school child. During the school years, however, the individual is evaluated very critically in terms of social and academic accomplishment. In later life the intellectual inadequacy again may be less evident if social performance meets the minimal demands. Very high prevalence at the ages of 10 to 14 is due primarily to the increased recognition of academic handicap of children within the school system. The low number of infants from birth to one year of age identified as retarded is in part attributed to the fact that their intellectual deficit is not yet apparent. Only gross impairment is evident in early childhood. Of striking significance is the fact that more than half of the individuals considered retarded during adolescence are no longer identified as such during adulthood.

In view of these considerations only gross estimate of the over-all magnitude of the problem can be established. One such estimate may be derived through measures of intelligence. Experience has shown virtually all children with I.Q.'s below about 70 on most standardized tests have significant difficulty in learning and in adapting adequately to their environment. About 3% of the population score below this level on a national average. Statistics in Hawaii State indicate that 2.0% of the population may be functioning at retarded levels. (See page 35)

RANGE OF SERVICES

The mentally retarded require an array of services that provide a "continuum of care" or "spectrum of opportunity" for all levels of retardation and for all age groups. All services must be correlated to provide maximum efficient use of available financial and personnel resources and to insure full coverage of needs of the retarded. (See also Definitions from Federal regulations, pages 24-26.)

An adequate and thorough diagnosis and evaluation of all retarded persons is essential for properly planning individual programs which meet specific needs.

Both short-term and long-term planning for treatment, training, education and care or supervision of the individual and counseling of parents are dependent upon the quality of the diagnosis and evaluation services provided to the patient. Diagnostic and evaluation services are the keystone to development of a complete array of services in any community or region.

Inclusion of the full range of specialized medical and related services is important as retardates require the same basic care as the non-handicapped.

Mental retardation is frequently complicated by problems of associated physical disability, emotional disturbances, impaired hearing, difficulty in perceiving, impaired vision, poor muscular coordination and physical deformities. The existence of these correlative conditions emphasizes the need for comprehensive diagnosis and evaluations prior to the development of individual programs for treatment, education, training, care services or sheltered employment. Increased survival rates will probably increase the number of retarded persons with associated physical handicaps in the future.

The basic functions of the educational programs for the children of pre-school age are the following:

1. To develop self-help skills, such as dressing and grooming.

2. To develop pre-academic skills.

3. To provide socialization and group training.

4. To promote environmental enrichment for the culturally deprived.

5. To improve intellectual experience and motivation.

Educational services for the retarded of school age encompass the curriculum of instruction for those unable to keep abreast of the normal public school program. The content of such a curriculum must relate to the capacities of the individual whom it serves. Vocational training includes the following: vocational evaluation, counseling, systematic planned instruction for sheltered or competitive employment, placement and follow-up services.

Along with these training services are coordinated programs of diversified activities providing opportunities for individual learning and participation (group activity services). Supervised housing arrangements (referred to as half-way houses) which may include counseling and group activities for small groups of mentally retarded individuals capable of relatively independent living or for individuals needing opportunities to become oriented to community life also play a very worthwhile role.

For those in the lower levels of retardation, training services should provide opportunities for the development of behavior patterns, self-care skills, social skills, health habits and attitudes, money management and many others.

Training may be provided on an individual or group basis. Programs must be compatible with the present developmental levels, learning characteristics and potentials for future development of the retardates involved.

For the younger retarded person, training programs usually emphasize selr-help, basic communication and inter-personnel skills. For the older or more capable individual training programs will generally stress activities which provide opportunities to acquire skills in handling participation in family, community and economic life. Included are programs available during their school age years, but who are too handicapped to be acceptable in a vocational training or sheltered workshop program.

Personal care services involve much more than programs designed solely to furnish food, clothing and shelter. These services should only be maintained where treatment, education and/or training services are provided within the same facility in order to bring the individual involved to a higher level of function.

Sheltered workshop services have two major aspects, transitional and extended employment. In transitional employment the major goal is eventual placement in community employment. Such a program gives considerable emphasis to training, evaluation and placement programs as well as to actual employment ties. In the extended employment program the emphasis is upon a broad range of work activities for those who cannot function satisfactorily in competitive employment.

There are certain advantages in providing the mentally retarded with sheltered workshop services in programs which include other handicapped individuals. For some of the mentally retarded such programs can permit broader opportunities for socialization experience and widen the range of job contacts that can be fulfilled. These benefits can be realized only, however, if the staff of the multi-purpose workshop recognizes the special needs of the retarded, particularly the longer training time frequently required.

The following definitions of services and facilities are used in the inventory for this State Plan:

1. Services

   a. Diagnostic Services

      Coordinated medical, psychological and social services, supplemented where appropriate by nursing, educational or vocational services, and carried out under the supervision of personnel qualified to: 1) diagnose, appraise, and evaluate mental retardation and associated disabilities, and the strengths, skills, abilities and potentials for improvement of the individual; 2) determine the needs of the individual and his family; 3) develop recommendations for a specific plan of services to be provided with necessary counseling to carry out recommendations; and 4) where indicated, periodically reassess progress of the individual.

b. Treatment Services

Services under medical direction and supervision providing specialized medical, psychiatric, neurological, or surgical treatment, including dental therapy, physical therapy, occupational therapy, speech and hearing therapy, or other related therapies which provide for improvement in the effective physical, psychological or social functioning of the individual.

c. Educational Services

Services under the direction and supervision of teachers qualified in special education, which provide a curriculum of instruction for pre-school children, for school age children unable to participate in public schools, and for the mentally retarded beyond school age.

d. Training Services

Services which provide; 1) training in self-help and motor skills; 2) training in activities of daily living; 3) vocational training; 4) opportunities for personality development; and 5) experiences conducive to social development, and which are carried out under the supervision of personnel qualified to direct these services.

e. Custodial Services

Services which provide personal care including, where needed, health services supervised by qualified medical or nursing personnel. Personal care covers food, shelter, hygienic attention, and clothing for 24 hours a day or any part thereof.

f. Sheltered Workshop Services

Services involving a program of paid work which provides; 1) work evaluation; 2) work adjustment training; 3) occupational training; and 4) transitional or extended employment, and which is carried out under the supervision of personnel qualified to direct these activities.

2. Facilities

   a. Diagnostic and Evaluation Facility

      A facility which accommodates an adequate proper staff to accomplish coordinated medical, psychological and social services which are supplemented where appropriate by nursing, educational or vocational personnel qualified to perform diagnostic services (see 1a, page 24).

   b. Day Facility

      A facility housing treatment, education, training, custodial or sheltered workshop services on less than a 24 hour a day basis.

   c. Residential Facility

      A facility which accommodates those individuals who by reason of necessity must remain on the premises on a 24 hour a day basis for purposes of treatment, education, training, custodial care or sheltered workshop services.

RELATIONSHIP TO OTHER PLANNING EFFORTS

The State Department of Health is willing and eager to cooperate with other agencies in any mental retardation planning efforts related to services and facilities. The Hospital and Medical Facilities Branch works with Children's Health Services Division, Waimano Training School and Hospital, Health Education Office and Research and Statistics Office within the Department of Health in planning developments.

The Department of Health works with the Department of Education, Department of Social Services, and Department of Accounting and General Services in various kinds of planning. In mental health, mental retardation and vocational rehabilitation planning has been interdepartmental as well as with Federal, County, City and private agencies. Comprehensive Health Planning Office, Department of Health, also brings together various groups for joint efforts.

CHAPTER IV

. . . UNIQUE PLANNING CONSIDERATIONS IN HAWAII

. . . DELINEATIONS OF PLANNING AREAS

. . . BASIS FOR PLANNING SERVICES

. . . SURVEYS OF CLIENTS

. . . PERCENTAGE OF MENTALLY RETARDED PERSONS

. . . GENERIC SERVICES

. . . SPECIAL PROJECTS

UNIQUE PLANNING CONSIDERATIONS IN HAWAII

The State of Hawaii is unique in that it is composed of a group of islands surrounded by open sea which recently was declared by the U. S. Federal Court to be "international waters." Thus, the islands' boundaries end at the waterline and each island is geographically isolated with its services generally inaccessible to the others.

Two scheduled airlines provide regular daily transportation between islands, but due to relatively high cost, such travel is not readily available to the average family.

The geographical isolation and non-contiguity of political boundaries, the widely scattered small population clusters pocketed usually along the shorelines and coastal regions of each island present special problems in the planning for the provision of adequate mental retardation coverage.

DELINEATION OF PLANNING AREAS

For the mental retardation program the State has been divided into the four major county areas of Hawaii, Maui, Kauai and the City and County of Honolulu. The fifth county, Kalawao, has not been considered as all its services are provided by the State Department of Health for the Hansen's Disease patients and delineation of these service areas.

With special attention to factors such as travel time, in the County of Hawaii and in the City and County of Honolulu further divisions of planning areas were made to meet certain needs of the residents. Area breakdowns for specific programs will appear in the respective chapters.

Population* in Mental Retardation Planning Areas

County	Islands	Population	
		1968	1974
Hawaii	Hawaii	65,700	71,000
Maui	Maui, Molokai, Lanai	48,200	52,000
Honolulu**	City of Honolulu, Oahu	347,450	374,980
Honolulu	Leeward Oahu	142,860	154,170
Honolulu	Windward Oahu	91,590	98,850
Kauai	Kauai, Niihau	31,200	34,000
TOTALS		727,000	785,000

*Provisional estimates of the U.S. Bureau of the Census (Series p-25, No. 414, dated January 28, 1969).

**Honolulu County (Island of Oahu) is divided into the following three Planning Areas:

City of Honolulu, Oahu, composed of census tracts #1-72

Leeward Oahu, composed of census tracts #73-100

Windward Oahu, composed of census tracts #101-113

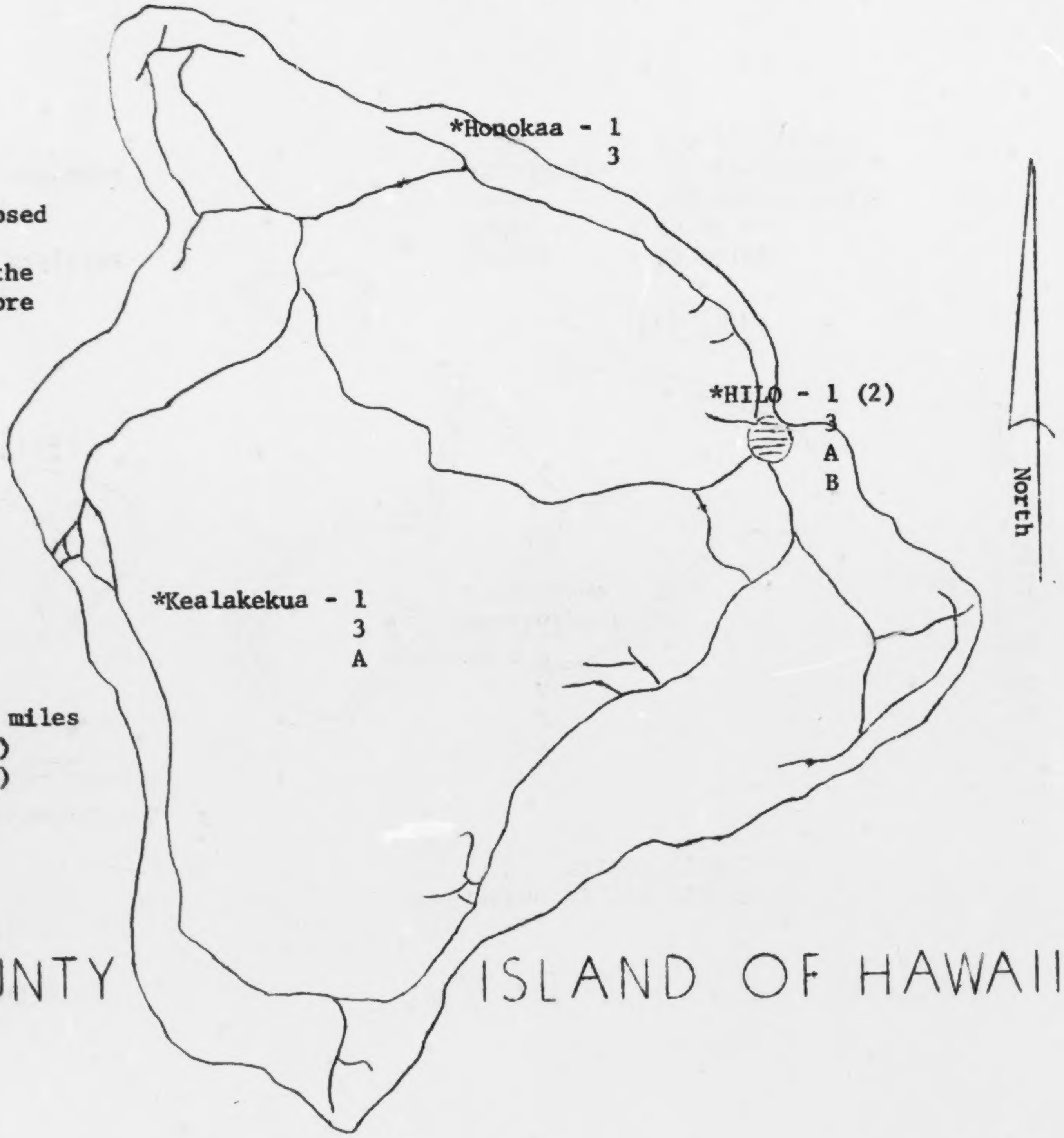
HAWAII COUNTY ISLAND OF HAWAII

CODE

1 - Day Care Existing
3 - D & E Itinerant
A - Day Care Proposed
B - Residential Care Proposed

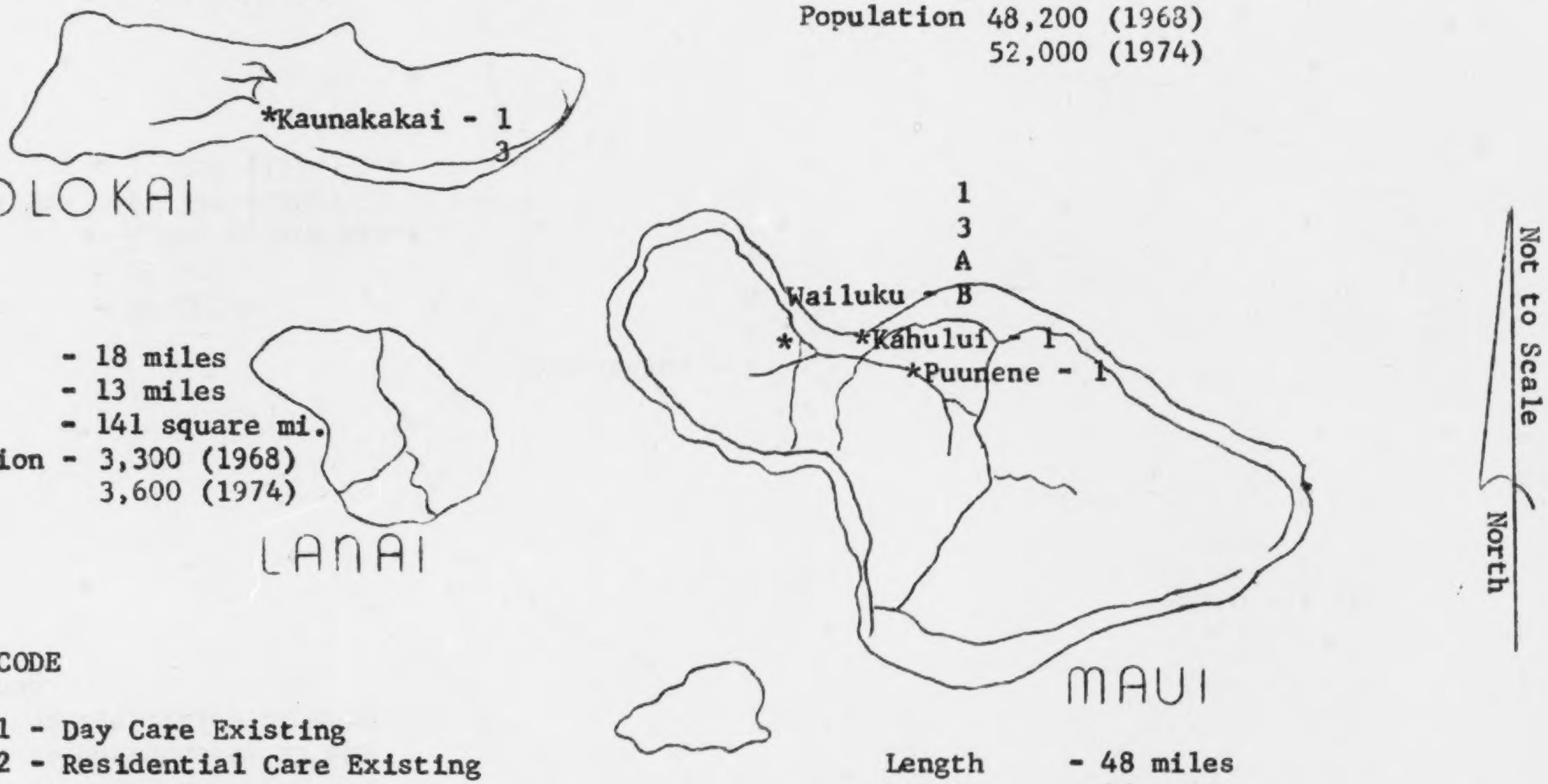
Number in parenthesis is the number of facilities if more than one.

Length - 93 miles
Width - 76 miles
Area - 4,021 square miles
Population - 65,700 (1968)
71,000 (1974)


*Honokaa - 1
3
*HILO - 1 (2)
3
A
B
*Kealakekua - 1
3
A
North

MAUI COUNTY

Population 48,200 (1968)
52,000 (1974)


*Kaunakakai - 1
3
MOLOKAI
LANAI
1
3
A
Wailuku - B
*
*Kahului - 1
*Puunene - 1
MAUI
Not to Scale
North

MOLOKAI

Length - 38 miles
Width - 10 miles
Area - 259 square miles
Population - 5,900 (1968)
6,400 (1974)

LANAI

Length - 18 miles
Width - 13 miles
Area - 141 square mi.
Population - 3,300 (1968)
3,600 (1974)

MAUI

Length - 48 miles
Width - 26 miles
Area - 728 square miles
Population - 39,000 (1968)
42,000 (1974)

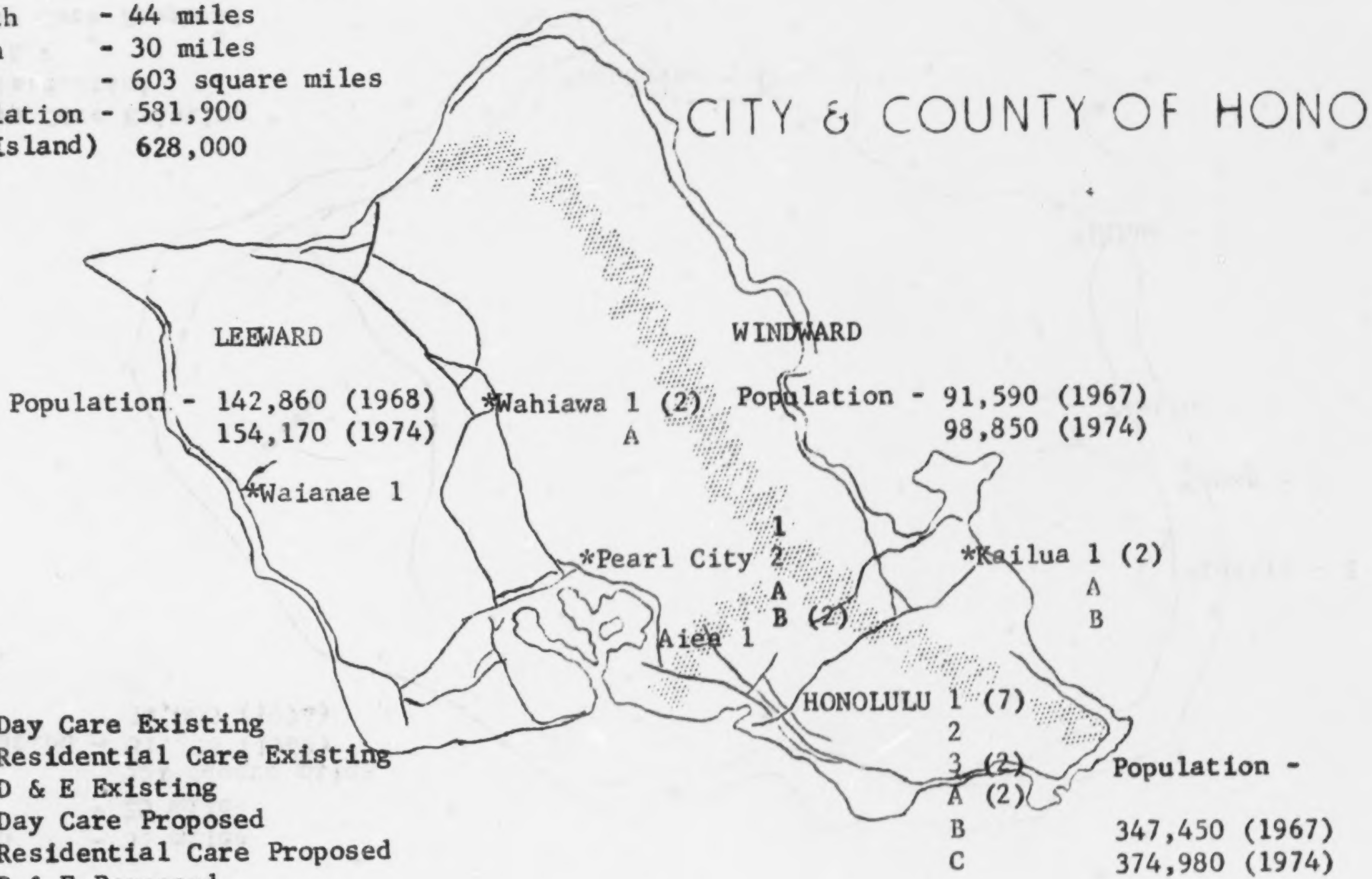
CODE

1 - Day Care Existing
2 - Residential Care Existing
3 - D & E Itinerant
A - Day Care Proposed
B - Residential Care Proposed

ISLAND OF OAHU

CITY & COUNTY OF HONOLULU

Length - 44 miles
Width - 30 miles
Area - 603 square miles
Population - 531,900
(Total Island) 628,000


LEEWARD
Population - 142,860 (1968)
154,170 (1974)
*Waianae 1
*Wahiawa 1 (2)
A
WINDWARD
Population - 91,590 (1967)
98,850 (1974)
*Pearl City 1
2
A
B (2)
Aiea 1
*Kailua 1 (2)
A
B
HONOLULU 1 (7)
2
3 (2)
A (2)
B
C
Population -
347,450 (1967)
374,980 (1974)

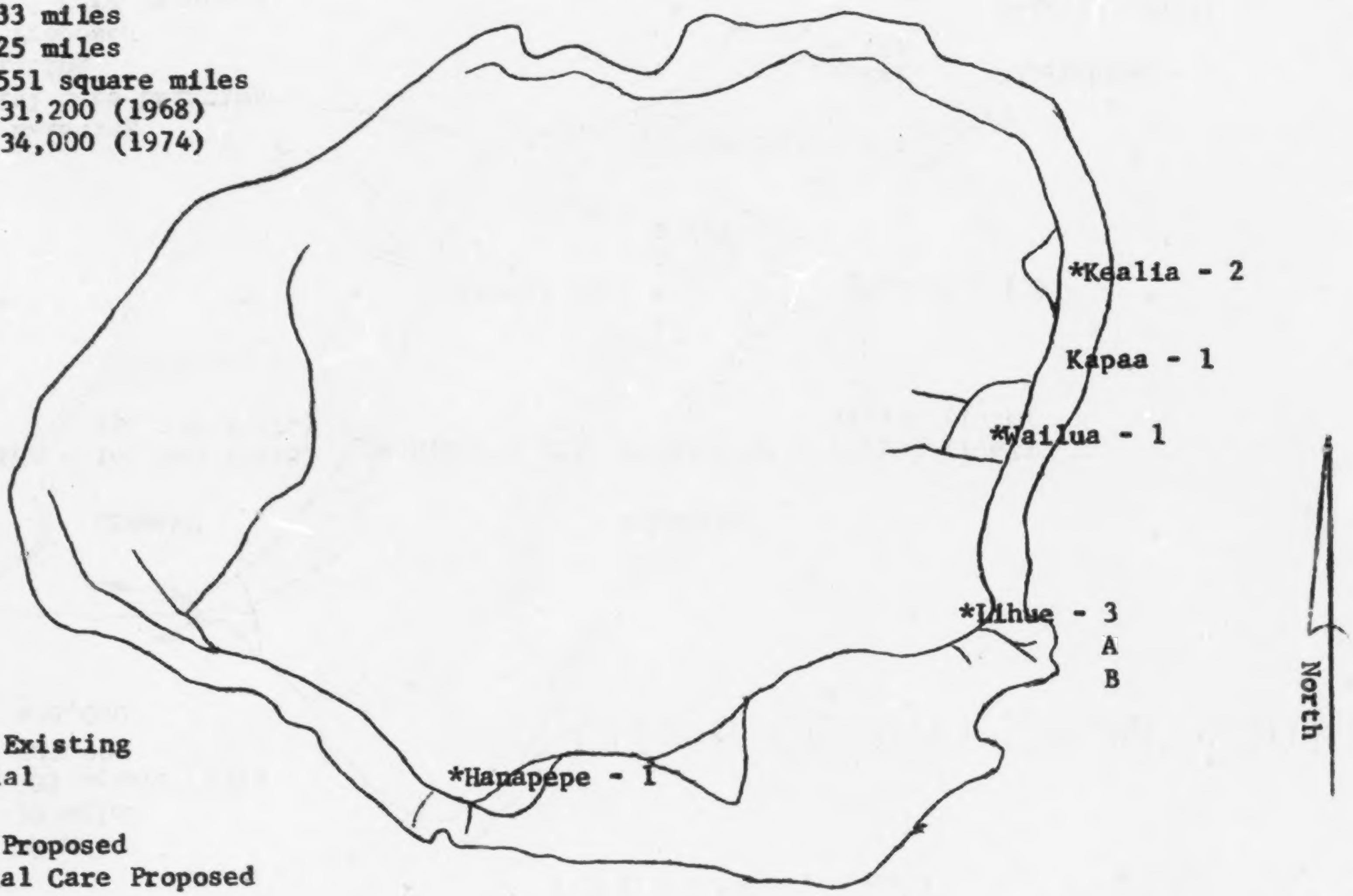
CODE

1 - Day Care Existing
2 - Residential Care Existing
3 - D & E Existing
A - Day Care Proposed
B - Residential Care Proposed
C - D & E Proposed

Number in parenthesis is the number of facilities if more than one.

ISLAND OF KAUAI

Length - 33 miles
Width - 25 miles
Area - 551 square miles
Population - 31,200 (1968)
34,000 (1974)


*Kealia - 2
Kapaa - 1
*Wailua - 1
*Lihue - 3
A
B
*Hanapepe - 1
North

CODE
1 - Day Care Existing
2 - Residential
3 - D & E
A - Day Care Proposed
B - Residential Care Proposed

Number in parenthesis is the number of facilities if more than one.

DETERMINING THE PERCENTAGE OF MENTALLY RETARDED PERSONS AMONG HAWAII'S POPULATION

It is not possible to say precisely how many mentally retarded people live in Hawaii. A random door-to-door survey might yield approximate percentages which could then be proportionately projected with the total population. Such a study would be expensive, time consuming, and not too accurate as those responding to the interview might not know whether a child were retarded, unless an actual diagnosis had been completed.

A more realistic approach is attempted for this Plan. It examines a controlled sampling which covers nearly one-third of the people in the State of Hawaii--the school-age population. This is the group for which the most complete and detailed records are available, due to the State law of mandatory school attendance until age 18.

The academic challenges of the classroom tend to separate the non-achievers who may then be referred for diagnosis and placed in special classes for slow learners, etc.

Additional information is added to these records of the school-age group such as enrollments of the mentally retarded in special centers for the handicapped.

It is recognized that this age group also includes others such as school dropouts, and perhaps a few homebound cases unknown at present.

Considerable interest is developing in the school dropouts as a group. A dropout generally has experienced more academic failures than his former classmates. His I.Q. is likely to be lower, but there is no actual evidence which would justify calling dropouts a high risk group, with reference to the possibility of their being retarded. Several local agencies are conducting studies on this group, but more information is needed before any basis can be formulated for projecting special M.R. services.

The following summary itemizes Hawaii's 1968 school-age population and the number diagnosed as mentally retarded.

Services for School-Age M.R.	School-Age Population	Diagnosed M.R.
1. Public & Private School Enrollment December, 1967	205,750	2,792
2. Special Programs (school age only)		
a) M.R. Services*	893	893
b) Vocational Rehabilitation	353	353
TOTALS	206,996**	4,038***

*Includes school-age enrollments of M.R. facilities surveyed, (see pages 48-51) plus 6 on Community Placement from Waimano.

**School-age group has 28.5% of all population in Hawaii.

***School-age group has 48.9% of all known M.R.'s in Hawaii.

The table shows that at least 4,038 persons, or 1.95% (rounded to 2.0%) of the State's school-age population has been diagnosed as mentally retarded. Additional data sources are being explored*; such as, caseloads of public health nurses and medical social workers, and the results of studies of school dropouts, but the information gained to date, although still incomplete, suggests that the number is negligible. This figure (2.0%) as the result of the foregoing representative sampling study, will be used for projecting numbers of the retarded among the entire population of Hawaii State (all ages) on pages 43-44.

When applied over the entire population, this percentage of 2.0 will produce "maximum projections" because it has been based on the age group at which those functioning at retarded levels are most readily identified. The school-age years generally present greater academic challenges than the years of adulthood. Many adults, although retarded, are capable of performing adequately in environments which are not too demanding.

There are problems in identifying the mentally retarded. Only the obvious cases are recognized at birth, while others gradually may be introduced to various services after the child fails to respond successfully to the demands of life.

When the young person does not adequately achieve the normal academic goals in the school system, he may be recommended for a class for slow learners. This is sometimes the parents' first suspicion that their child might be retarded. Unless they respond by enrolling the child in some helpful program, they very sadly jeopardize his personal growth and betterment.

*Department of Education, June, 1969, record indicated 1,149 students on waiting list for Psychological Evaluation.

Enrollments in Community
Mental Retardation Facilities by Counties - 1968
(Excluding Public Schools)

Degree of Retardation	Hawaii County	Maui County	Honolulu County	Kauai County	Hawaii State
Mild	77	33	464	31	605
Moderate	49	23	421	31	524
Severe	24	8	390	13	435
Profound	1	0	276	0	277
TOTAL	151	64	1,551	75	1,841

Above table includes M.R. facilities survey figures, but does not include those enrolled or waiting in public schools. Waimano Training School and Hospital figures are counted here as Honolulu County enrollments. Compare with table on page 72 which counts Waimano clients with the counties from which they were admitted.

SPECIAL EDUCATION CLASSES
HAWAII STATE DEPARTMENT OF EDUCATION

The Department of Education provides classes for mentally retarded students who can benefit from a classroom experience at either the educable or trainable level. The Mentally Retarded Educable (MRE) children are legal school-age children who, due to limited intellectual endowment, are unable to make satisfactory progress and adjustment in a regular school program. They find difficulty primarily in the areas of school activity associated with academic learning. However, they show potential for some academic educability as measured by individual psychological instruments. The I.Q., although not the single determining factor, should range between 50-75 on the Stanford-Binet, WISC, WAIS, or other individual psychological instrument approved by the Department of Education, and administered by a qualified psychologist approved by the Department of Education.

Public School Enrollments of Mentally Retarded Educables 1968-69

Planning Area	Enrolled 10/68	Diagnosed 10/68 to 6/69	Expected Enrollment 9/69
Hawaii	360	63	423
Maui	146	57	203
Honolulu	508	80	588
Leeward*	627	135	792
Windward	263	25	288
Kauai	124	5	129
SUBTOTAL	2,028	365	2,393
Special School (Linekona - as interviewed)	107		107
GRAND TOTAL	2,135	365	2,500

*The Leeward Oahu M.R. Planning Area includes both Leeward and Central Oahu School Districts.

Source: Hawaii State Department of Education, Division of Guidance and Special Education.

The Mentally Retarded Trainable (MRT) child is one with the condition that "refers to sub-average general intellectual functioning which originates during the developmental period and is associated with impairment in adaptive behavior" (AAMD, 1961). This child will have intellectual deficit to the extent that he will not benefit from placement in the MRE program. Although their literacy potential is severely impaired or lacking, they can be trained in areas of self-care and partial occupational independence. I.Q., although not the single determining factor, should range between 30-50 on the Stanford-Binet, WISC, WAIS or other individual psychological instrument approved by the Department of Education, and administered by a qualified psychologist approved by the Department of Education.

According to the State Laws of Hawaii, no elementary school student can be made to repeat any grade more than once, nor can he be "failed" more than twice within the duration of his schooling. This increases the need for special classes for those who are unable to compete with their average classmates.

Public School Enrollments for Mentally Retarded Trainables
1968-69

Planning Area	Enrolled 10/68	Diagnosed 10/68 to 6/69	Expected Enrollment 9/69
Hawaii	35	0	35
Maui	19	0	19
Honolulu	17	5	22
Leeward	70	9	79
Windward	24	10	34
Kauai	17	0	17
SUBTOTAL	132	24	206
Special Schools	86		86
GRAND TOTAL	268	24	292

*The Leeward Oahu M.R. Planning Area Includes both Leeward and Central Oahu School Districts.

Source: Hawaii State Department of Education, Division of Guidance and Special Education.

Another Hawaii State Law which may create further need for additional classes for the mentally retarded went into effect September 1, 1966 (Section 40-9). It requires the attendance in school of all individuals until they are 18 years old. Aimed at discouraging dropouts who are usually performing at sub-academic levels prior to their withdrawing from school, this law should benefit many of the borderline retarded cases.

The percentage of known mental retardates may increase slightly as better records are kept and as follow-up services are improved. Accumulative totals indicating how many mentally retarded students are being graduated from special training and education classes and rehabilitation programs would be helpful in determining more accurate ratios for projection of future needs.

It is assumed that many inactivated cases will be again in need of certain services which could conceivably range from infrequent counseling to residential supervised care.

Summary of Known Mentally Retarded Individuals in Hawaii
All Ages

Sources of Data*	Hawaii County	Maui County	Oahu	Kauai County	State of Hawaii
1. M.R. Facilities Survey	151	64	1,551	75	1,841
2. Waimano - placement	25	21	364	30	440
a. Discharged cases	2		280		282
3. Vocational Rehab.	103	146	567	90	906
a. Graduated	198	228	889	162	1,477
b. Disabled on Social Security			513		513
4. Dept. of Education	458	222	1,966	146	2,792
COUNTY TOTALS	937	681	6,130	503	8,251

*Sources:

1. M.R. facilities survey for calendar year 1968, Hawaii State Mental Retardation Facilities Construction Program.

2. Waimano Community Placement - active file.
   a. Accumulative cases discharged from Waimano, 1942-1968.

3. Office of Vocational Rehabilitation - active file.
   a. Graduated from training classes 1961 to June, 1969.
   b. Disabled and receiving social security benefits as surviving dependents of deceased parents. (No breakdown by Islands before 1969, but most of the State total is on Oahu.)

4. Department of Education---1968-69 enrolled or waiting for M.R. classes. (No accumulative record available for those either graduated or withdrawn from classes.)

The National Association for Retarded Children uses a figure of three per cent of the general population to estimate the number affected by some degree of retardation. The State of Hawaii can justify use of only a two per cent figure for projection purposes. (See preceeding study of the school-age population.)

It should be mentioned that the State of Hawaii has no slums or ghettos of the magnitude witnessed in many large cities across the Mainland U.S.A. which are generally considered "high risk" areas. Hawaii also has no rural areas which are truly isolated from health services. Traveling teams of public health nurses, therapists and social workers reach all rural areas on a regular schedule.

It is felt that these factors suggest reasons why Hawaii may have a lower incidence of retardation than the Mainland average.

The number of annual live births in the State of Hawaii is shown below with estimates of how many may be performing at retarded levels.

Estimated Annual Increase in M.R. Population
from Births in the State of Hawaii

Year	Mid Year Population*	Birth Rate	Actual Births	Estimated M.R. Increase 2% of Births
1961	612,673	28.6	17,558	351
1962	635,888	28.2	17,932	359
1963	655,546	27.1	17,744	355
1964	674,951	25.6	17,284	346
1965	702,030	23.1	16,259	325
1966	713,909	20.9	14,943	299
1967	759,582	19.5	14,775	295
1968	760,514	18.3	14,470	289

*Hawaii State Department of Health: De facto civilian population. Provisional estimate 1968.

This 8-year review of Hawaii's births indicates a decline which has been quite steady in number of births as well as a decrease in birth rate. This trend should be accompanied by a reduction in the annual number of retardates born. The 1968 estimated increase in the mentally retarded population from births, is 62 persons less than the estimated increase for 1961.

When the 2.0% figure is applied to the July 1, 1968 population for the State of Hawaii** the number of mentally retarded

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**Department of Health, Office of Research and Statistics. See also table on page 41.

individuals reaches 15,210. The vast majority of these, however, are only mildly affected and require no more than minimum services, if any. For statistical purposes, retardates are divided into groups based on their relative degree of mental handicap. According to the experience of the National Association for Mental Retardation, the State's total number of cases should reflect approximately the following percentages in each category: (See also Developmental Characteristics, page 20).

Degree of Retardation	Per Cent of M.R. Total
Mild (I.Q. of 50 to 70)	89%
Moderate (I.Q. of 35 to 50)	6%
Severe (I.Q. of 20 to 35)	3.5%
Profound (I.Q. below 20)	1.5%

These percentages, when applied to the 1968 births for the State of Hawaii, by counties, would yield the following estimated numbers of new retardates.

Hawaii State Total (Estimated) Retardates Born 1968

Degree of Retardation	Hawaii County	Maui County	Oahu County	Kauai County	State Total
Mild	17	14	217	9	257
Moderate	1	1	15	1	18
Severe	1	1	8	0	10
Profound	0	0	4	0	4
Total Retarded*	19	16	244	10	289
Total Births	975	786	12,221	488	14,470

*Estimate formed by multiplying 2.0% times the actual births.

ESTIMATED RETARDATES BY COUNTY AND M.R. LEVEL
(AS OF ESTIMATED POPULATION PROJECTED TO 1974)
BASED ON 2.0% OF GROSS POPULATION

(Totals may vary slightly due to rounding)

AGE GROUP	COUNTY	HAWAII	MAUI	HONOLULU	HONOLULU	HONOLULU	KAUAI	STATE TOTAL
	ISLANDS	Hawaii	Maui Molokai Lanai	Oahu	Oahu	Oahu	Kauai	
	Designation	Hawaii	Maui	Honolulu	Leeward	Windward	Kauai	
	Total Population	71,000	52,000	374,980	154,170	93,850	34,000	785,000
0-4	No. in Age Group	9,088	6,656	47,997	19,734	12,653	4,352	100,480
	M.R. - Mild	162	118	854	352	225	77	1,789
	Moderate	11	8	58	24	15	5	121
	Severe	6	5	34	14	9	3	70
	Profound	3	2	14	6	4	1	30
	TOTAL M.R.	182	133	960	396	253	86	2,010
5-19	No. in Age Group	21,513	15,756	113,619	46,714	29,952	10,302	237,856
	M.R. - Mild	383	280	2,022	831	533	183	4,233
	Moderate	26	19	136	56	36	12	285
	Severe	15	11	80	33	21	7	166
	Profound	6	5	34	14	9	3	71
	TOTAL M.R.	430	315	2,272	934	599	206	4,756
20-40	No. in Age Group	21,655	15,860	114,369	47,022	30,149	10,370	239,425
	M.R. - Mild	385	282	2,035	837	537	184	4,262
	Moderate	26	19	137	56	36	12	287
	Severe	15	11	80	33	21	7	168
	Profound	6	5	34	14	9	3	72
	TOTAL M.R.	433	317	2,287	940	603	207	4,789

(Continued)

Estimated Retardates by County & M.R. Level

AGE GROUP	Designation	Hawaii	Maui	Honolulu	Leeward	Windward	Kauai	STATE TOTAL
40-60	No. in Age Group	13,703	10,036	72,371	29,755	19,078	6,562	151,505
	M.R. - Mild	244	179	1,288	530	340	117	2,697
	Moderate	16	12	87	36	23	8	182
	Severe	10	7	51	21	13	5	106
	Profound	4	3	22	9	6	2	45
	TOTAL M.R.	274	201	1,447	595	382	131	3,030
60+	No. in Age Group	5,041	3,692	26,624	10,946	7,018	2,414	55,735
	M.R. - Mild	90	66	473	195	125	43	992
	Moderate	6	4	32	13	8	3	67
	Severe	4	3	19	8	5	2	39
	Profound	2	1	8	3	2	1	17
	TOTAL M.R.	101	74	532	219	140	43	1,115
	Total Population	71,000	52,000	374,980	154,170	98,850	34,000	785,000
	Total - Mild	1,264	926	6,675	2,744	1,760	605	13,973
	Moderate	85	62	450	185	119	41	942
	Severe	50	36	263	108	69	24	550
	Profound	21	16	112	46	30	10	235
	TOTAL M.R.	1,420	1,040	7,500	3,083	1,977	680	15,700

ANALYSIS OF GENERIC SERVICES

The Department of Health, through the Waimano Training School and Hospital Division and through the Children's Health Services Division, offers a variety of services ranging from residential and treatment at Waimano to diagnostic and evaluation through comprehensive team evaluation services for children on a statewide basis.

Approximately one fourth of the Waimano Community Placements are residing in Care Homes.

Care Home definition: A facility which provides general or rehabilitative care incident to old age or disability to two or more persons unrelated to the operator for which care payment is received. These homes exclude admission of residents less than semi-ambulatory or those needing long-term nursing care.

The following listing shows the Care Homes which accept mentally retarded clients.

Planning Area	Number of M.R.'s
HAWAII COUNTY	
No Care Homes	0
MAUI COUNTY	
M. Domingo Home	2
Domingo Home	3
Maui Total 2 Care Homes	5
HONOLULU	
Cachola Home	4
Guillermo Home	3
Glory's Care Home	2
Hale Malamalama	1
Hale Nani	1
Hanakealoha Care Home	2
Hosino Home	2
Kauwalu Home	4
Korean Old Men's Home	1
Lanihuli Care Home	2
Madriaga Home	1
Malingdan Care Home	3
Miguel Home	4
Martinez Care Home	1
Paradise Home	4
HONOLULU (continued)	
Saguyan Home	1
Silao	1
Tabios Home	3
Yonamine	1
Honolulu Total 19 Care Homes	41
LEEWARD OAHU	
Agsalda Home	1
Bello Home	1
Cabana Home	4
Dombrigue Home	1
Francisco Home	3
Hamada	2
Jane's	3
Kansaki Care Home	2
Menor Home	2
Nakata Care Home	1
Noll Care Home	3
O'Claray Home	1
Omalza Care Home	1
Rosa Home	2
Patoc Care Home	1
Suga Home #1	3

Planning Area	Number of M.R.'s
LEEWARD OAHU (continued)	
Tapangco Home	1
Tano Care Home	1
Valbuena Home	1
Ventura Home	4
Wong Home	2
Leeward Total 21 Care Homes	40
WINDWARD OAHU	
Clio's Home	3
Leleo Home	4
Terrenal Care Home	2
Keim Care Home	3
Windward Total 4 Care Homes	12

Planning Area	Number of M.R.'s
KAUAI COUNTY	
Iida Home	3
Omine Home	3
Kauai Total 2 Care Homes	6

Total Hawaii State: 48 Care Homes; 104 M.R.'s

Legislation mandating the testing of all newborn for phenylketonuria (PKU) was passed February 19, 1966 and amended July 1, 1966. Public Health Regulations for testing of newborn infants for this hereditary metabolic disease may be found in the Appendix, page 125.

It is estimated that PKU occurs once in every 10,000 to 40,000 live births, with somewhat higher incidence among offspring from European stock and particularly low in those of Negro ancestry and of Ashkenazim Jewish extraction.

Although no new cases have been reported, the Health Department's Medical Health Services Division, Nutrition Branch, is presently providing services to five cases which were known before the legislation was passed.

Other special projects may be found in the Appendix.

CHAPTER V

. . . INVENTORY OF EXISTING FACILITIES AND SERVICES

. . . ANALYSIS OF EXISTING FACILITIES

. . . INVENTORY OF SERVICES AND FACILITIES

. . . REVIEW OF PROGRAMED FACILITIES

CODE SHEET - GENERAL DATA

The following information clarifies the codes appearing in the forms (PHS 4774-1) Inventory - General Data on the next five pages.

3. Definitions of these facilities and services are provided in the Regulations (Section 54:104) pages . A diagnostic clinic, day facility, and residential facility in any possible combination may be located: (a) within the same building, (b) on the same contiguous campus. More than one program may be checked, if applicable.

4. - 5. Type of ownership of property and sponsorship of program within facility.

NONPROFIT	PUBLIC	PROPRIETARY
01 Community nonprofit association	11 City	21 Individual
02 Church	12 County	22 Partnership
03 Fraternal order	13 State	23 Corporation
04 Other nonprofit	14 Other public	24 Other proprietary

6. Interest of program sponsor in the land upon which the facility is located. A-own; B-rent or lease; C-free use.

7. The number of buildings by design classification are recorded by the following code letters:

A. Originally designed as a facility for the mentally retarded.
B. Remodeled into a facility for the mentally retarded.
C. Not designed or remodeled as a facility for the mentally retarded.

8. The originally designed buildings (Column 7A) are also described as Suitable (Column 8A) or Unsuitable (Column 8B) on the basis of established criteria for structural adequacy.

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INVENTORY - General Data

Area	Location		Name of Facility	Type of Facility			Ownership or Control of Property	Sponsorship of Program	Sponsor's Interest in Property	Number of Buildings in Facility Classified by M.R. Design			Number of Buildings Showing Structural Suitability		Total Number of Mentally Retarded Individuals Served in the Facility							
	City or Town	County		Diagnostic and Evaluation Clinic	Day Facility	Residential Facility									Total	Level of Retardation				Age Grouping		
																Mild	Moderate	Severe	Profound	Pre-School	School Age	Adult
				A	B	C				A	B	C	S	U								
1	2a	2b	2c	3a	3b	3c	4	5	6	7a	7b	7c	8a	8b	9	10a	10b	10c	10d	11a	11b	11c
Hawaii	Hilo	Hawaii	Big Island Tr. Cr.		X		12	01	C		1				8	2	2	4		1	7	
"	"	"	Child Dev. Cl.	X			13	13	A	4			4		31*	17	8	5	1	2	29	
"	"	"	Rainbow Crafts		X		12	01	C		2				58	27	21	10			30	28
"	Honokaa	"	Brantley Center, Inc.		X		23	01	C			1			15	8	3	4			3	12
"	"	"	Honokaa Ch. Dev. Cl.	X			13	13	A			1	1		2**	1		1		1	1	
"	Kealakekua	"	Kona Ch. Dev. Cl.	X			13	13	A			1	1		30	19	11			2	18	10
"	"	"	Kona Assn. for Retarded Children		X		01	01	C		1				7	3	4				7	
			HAWAII COUNTY TOTALS	3	4					4	4	3	6		151	77	49	24	1	6	95	50

*Also receiving services were 13 others diagnosed "Not M.R." - Hilo
** " " " " 6 " " " " - Honokaa

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Area	Location: City or Town	Location: County	Name of Facility	Diagnostic and Evaluation Clinic A	Day Facility B	Residential Facility C	Ownership or Control of Property	Sponsorship of Property	Sponsor's Interest in Property	Number of Buildings in Facility Classified by M.R. Design A	B	C	Number of Buildings Showing Structural Suitability S	U	Total Number of Mentally Retarded Individuals Served in the Facility: Total	Level of Retardation: Mild	Moderate	Severe	Profound	Age Grouping: Preschool	School Age	Adult
1	2a	2b	2c	3a	3b	3c	4	5	6	7a	7b	7c	8a	8b	9	10a	10b	10c	10d	11a	11b	11c
Maui	Kahului	Maui	Ka Lima O Maui		X		04	04	C		1	1			31	23	8				1	30
"	Kaunakakai	"	Molokai Ch. Dev. Cl.	X			13	13	C			1			2*	2					2	
"	"	"	Molokai Trainable Cr.		X						1				7		5	2			7	
"	Puunene	"	Child Tr. Cr.		X		23	01	C		1				9	3	4	2			9	
"	Wailuku	"	Good Shepard Church Activity Center		X		2	2	C			1	1		6		4	2				6
"	"	"	Maui Ch. Dev. Cl.	X			13	13	C			1			9**	5	2	2		3	6	
			MAUI COUNTY TOTALS	2	4						3	4	1		64	33	23	8		3	25	36

*Also receiving services were 16 others (15 "Borderline" and 1 "Undetermined") - Molokai
** " " " " " " (13 " " 3 ") - Wailuku

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INVENTORY - General Data

Area	Location		Name of Facility	Type of Facility			Ownership or Control of Property	Sponsorship of Program	Sponsor's Interest in Property	Number of Buildings in Facility Classified by M.R. Design			Number of Buildings Showing Structural Suitability		Total Number of Mentally Retarded Individuals Served in the Facility							
	City or Town	County		Diagnostic and Evaluation Clinic	Day Facility	Residential Facility									Total	Level of Retardation				Age Grouping		
																Mild	Moderate	Severe	Profound	Preschool	School Age	Adult
				A	B	C				A	B	C	S	U								
1	2a	2b	2c	3a	3b	3c	4	5	6	7a	7b	7c	8a	8b	9	10a	10b	10c	10d	11a	11b	11c
Honolulu	Honolulu	Hon.	Children's Hospital Ch. Dev. Cl.	X			01	13	C			3			31	8	10	11	2	16	15	
"	"	"	Diamond Hd. Ch. Dev. Cr.		X		13	13	C		2				24*	5	11	8		11	13	
"	"	"	Diamond Hd. Ch. Dev. Cl.	X			13	13	C		1				165**	74	40	26	25	59	95	11
"	"	"	Happy Hale (HAHRC)		X		14	01	C			1			24		11	12	1	1	21	2
"	"	"	Kinau Tr. Cr. (HAHRC)		X		02	01	B			1			55	21	27	7		2	53	
"	"	"	Lanakila Crafts		X		13	04	B		1	2	1		163	145	23				60	108
"	"	"	Leahi Day Facility		X		13	13	A			1			37	2	6	28	1	18	19	
"	"	"	Leahi Res. Facility			X	13	13	A		1		1		52	19	8	23	2	24	20	3
"	"	"	Special Ed. Cr. of Oahu		X		04	23	B			3	3		44	31	13				44	
"	"	"	Voc. Dev. Cr. (HAHRC)		X		14	01	C			4			70	12	35	22	1		28	42
			HONOLULU TOTALS	2	7	1					5	15	5		670	317	184	137	32	131	363	171

*Also receiving services were 31 others diagnosed "Not M.R." at Children's Hospital C.D.C.
** " " " " 1,177 " " " " Diamond Head "

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INVENTORY - General Data

Area	Location: City or Town	Location: County	Name of Facility	Type of Facility: Diagnostic and Evaluation Clinic	Type of Facility: Day Facility	Type of Facility: Residential Facility	Ownership or Control of Property	Sponsorship of Program	Sponsor's Interest in Property	Number of Buildings in Facility Classified by M.R. Design			Number of Buildings Showing Structural Suitability		Total Number of Mentally Retarded Individuals Served in the Facility: Total	Level of Retardation: Mild	Level of Retardation: Moderate	Level of Retardation: Severe	Level of Retardation: Profound	Age Grouping: Preschool	Age Grouping: School Age	Age Grouping: Adult
				A	B	C				A	B	C	S	U								
1	2a	2b	2c	3a	3b	3c	4	5	6	7a	7b	7c	8a	8b	9	10a	10b	10c	10d	11a	11b	11c
Leeward	Aiea	Hon.	Aiea Cr. for Retarded Children		X		02	01	B			1			27	14	7	5	1	3	24	
"	Pearl City	"	Waimano Tr. Sch. & Hosp.			X	13	13	C	13	1	2	13		798	117	193	245	243	15	293	490
"	Wahiawa	"	Wahiawa Cr. for Retarded Children		X		01	01	A	1			1		10		8	2		1	9	
"	"	"	Wahiawa Vocational Development Center		X		01	01	A	2			2		10	3	7				8	2
"	Waianae	"	Waianae Ch. Tr. Cr.		X		13	13	B			1			7	1	5	1		3	4	
			LEEWARD TOTALS		4	1				16	1	4	16		852	135	220	253	244	22	338	492
Windward	Kailua	Hon.	Kailua Tr. Cr. (HAHRC)		X		02	01	B			1			14	7	7			2	12	
"	"	"	Kailua Voc. Dev. Cr.		X		02	01	B			1			15	5	10				10	5
			WINDWARD TOTALS		2							2			29	12	17			2	22	5
			ISLAND OF OAHU TOTALS	2	13	2				16	6	21	21		1551	464	421	390	276	155	728	668

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INVENTORY - General Data

Area	Location: City or Town	Location: County	Name of Facility	Type of Facility: A Diagnostic and Evaluation Clinic	Type of Facility: B Day Facility	Type of Facility: C Residential Facility	Ownership or Control of Property	Sponsorship of Program	Sponsor's Interest in Property	Number of Buildings in Facility Classified by M.R. Design: A	B	C	Number of Buildings Showing Structural Suitability: S	U	Total Number of Mentally Retarded Individuals Served in the Facility: Total	Level of Retardation: Mild	Moderate	Severe	Profound	Age Grouping: Preschool	School Age	Adult
1	2a	2b	2c	3a	3b	3c	4	5	6	7a	7b	7c	8a	8b	9	10a	10b	10c	10d	11a	11b	11c
Kauai	Hanapepe	Kauai	Child Tr. Cr.		X		02	04	B			1			7		7				7	
"	Kapaa	"	Child Dev. Cr.		X		02	04	B			1			10	1	6	3		1	7	2
"	Kealia	"	Samuel Mahelona Mem. Hospital			X	12	12	C			1			9	5	2	2			2	7
"	Lihue	"	Child Dev. Cl.	X			13	13	C			2			13*	6	10	2		1	17	
"	Wailua	"	Rehabilitation Unlimited Kauai		X		23	23	B			3			31	19	6	6			12	19
KAUAI COUNTY TOTALS				1	3	1						8			75	31	31	13		2	45	28

*Also receiving services were 10 others diagnosed "Not M.R." - Lihue

CODE SHEET - INVENTORY SERVICES DATA

The following information will clarify the codes used in the forms (PHS 4774-2) Inventory - Services Data found on the next five pages.

General: In terms of the definitions applicable to the mental retardation construction program under Title I, Part C of P.L. 88-164, (Section 54.104) a mental retardation facility may include three types of facilities which may exist independently: i.e., diagnostic/evaluation clinic; day facility; residential facility; or in combination of one of these types. It is important that information on each of these types be recorded separately if they exist: (a) within the same building, or (b) on the same contiguous campus.

3. The total number of mentally retarded persons served by the diagnostic and evaluation clinic portion of the facility during the past 12 months (calendar year 1967) is shown in column 3.

4. The total number of mentally retarded persons served in the day facility portion during the past 12 months (calendar year 1967) is shown in column 4A. The average daily caseload for each specified service offered in the day facility portion during calendar year 1967 is shown in columns 4B through 4F.

5. The total number of mentally retarded persons in the residential facility portion during calendar year 1967 is shown in column 5A. Average daily caseloads appear for residential services in columns 5B through 5F.

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INVENTORY - Services Data

Area	Location: City or Town	Location: County	Name of Facility	Diagnostic & Evaluation Clinic: Total Number Served	Day Facility: Total Number Served: Total	Day Facility: Average Daily Case Load in Services: Treatment	Education	Training	Custodial Care	Sheltered Workshop	Residential Facility: Total Number Served: Total	Residential Facility: Average Daily Case Load in Services: Treatment	Education	Training	Custodial Care	Sheltered Workshop
1	2a	2b	2c	3	4a	4b	4c	4d	4e	4f	5a	5b	5c	5d	5e	5f
Hawaii	Hilo	Hawaii	Big Island Tr. Cr.		8		2	8	8							
"	"	"	Child Dev. Cl.	31*												
"	"	"	Rainbow Crafts		58		19	26	58	13						
"	Honokaa	"	Brantley Center, Inc.		15			13	15	2						
"	"	"	Honokaa Ch. Dev. Cl.	2**												
"	Kealakekua	"	Kona Ch. Dev. Cl.	30												
"	"	"	Kona Assn. for Retarded Children		7		2	5	7							
			HAWAII COUNTY TOTALS	63	88		23	52	88	15						

*Also receiving services were 13 others diagnosed "Not M.R." - Hilo
** " " " " 6 " " " " - Honokaa

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INVENTORY - Services Data

Area	Location		Name of Facility	Diagnostic & Evaluation Clinic	Day Facility						Residential Facility					
	City or Town	County			Total Number Served	Average Daily Case Load in Services					Total Number Served	Average Daily Case Load in Services				
				Total Number Served	Total	Treatment	Education	Training	Custodial Care	Sheltered Workshop	Total	Treatment	Education	Training	Custodial Care	Sheltered Workshop
1	2a	2b	2c	3	4a	4b	4c	4d	4e	4f	5a	5b	5c	5d	5e	5f
Maui	Kahului	Maui	Ka Lima O Maui		31			10	31	15						
"	Kaunakakai	"	Molokai Ch. Dev. Cl.	2*												
"	"	"	Molokai Tr. Cr.		7			7	7							
"	Puunene	"	Child Tr. Cr.		9			9	9							
"	Wailuku	"	Good Shepard Church Activity Center		6				6							
"	"	"	Maui Child Dev. Cl.	9**												
			MAUI COUNTY TOTALS	11	53			26	53	15						

*Also receiving services were 16 others (15 "Borderline" & 1 "Undetermined") - Molokai
**Also receiving services were 16 others (13 " " 3 ") - Wailuku

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INVENTORY - Services Data

Location				Diagnostic & Evaluation Clinic	Day Facility						Residential Facility					
					Total Number Served	Average Daily Case Load in Services					Total Number Served	Average Daily Case Load in Services				
Area	City or Town	County	Name of Facility	Total Number Served	Total	Treatment	Education	Training	Custodial Care	Sheltered Workshop	Total	Treatment	Education	Training	Custodial Care	Sheltered Workshop
1	2a	2b	2c	3	4a	4b	4c	4d	4e	4f	5a	5b	5c	5d	5e	5f
Honolulu	Honolulu	Hon.	Children's Hosp. C.D.Cl.	31*												
"	"	"	Diamond Hd. Ch. Dev. Cr.		24			24	24							
"	"	"	Diamond Hd. Ch. Dev. Cr.	165**												
"	"	"	Happy Hale (HAHRC)		24			24	24							
"	"	"	Kinau Tr. Cr. (HAHRC)		55		55	55	55							
"	"	"	Lanakila Crafts		168			47	168	27						
"	"	"	Leahi Day Facility					9								
"	"	"	Leahi Res. Facility		37				37		52	12	6***	12	12	
"	"	"	Special Ed. Cr. of Oahu		44		44	16	44							
"	"	"	Voc. Dev. Cr. (HAHRC)		70			70	70	70						
			HONOLULU TOTALS	196	422		99	245	422	97	52	12	6	12	12	

*Also receiving services were 31 others diagnosed "Not M.R." (Children's Hospital C.D.C.)
** " " " " 1,177 " " " " (Diamond Head)
***Children sent out to special education classes

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INVENTORY - Services Data

Area	Location		Name of Facility	Diagnostic & Evaluation Clinic	Day Facility						Residential Facility					
	City or Town	County		Total Number Served	Total Number Served	Average Daily Case Load in Services					Total Number Served	Average Daily Case Load in Services				
					Total	Treatment	Education	Training	Custodial Care	Sheltered Workshop	Total	Treatment	Education	Training	Custodial Care	Sheltered Workshop
1	2a	2b	2c	3	4a	4b	4c	4d	4e	4f	5a	5b	5c	5d	5e	5f
Leeward	Aiea	Hon.	Aiea Center for Retarded Children		27		27	27	27							
"	Pearl City	"	Waimano Tr. Sch. & Hosp.		3			3	3		795	785	90	469	795	130
"	Wahiawa	"	Wahiawa Cr. for Retarded Children (HAHRC)		10		10	10	10							
"	"	"	Wahiawa Vocational Development Center		10			10	10	10						
"	Waianae	"	Waianae Ch. Trg. Cr.		7			7	7							
			LEEWARD TOTALS		57		37	57	57	10	795	785	90	469	795	130
Windward	Kailua	Hon.	Kailua Tr. Cr. (HAHRC)		14		14	14	14							
"	"	"	Kailua Vocational Development Center		15			15	15							
			WINDWARD TOTALS		29		14	29	29							
			ISLAND OF OAHU TOTALS	196	508		150	331	508	107	847	797	96	481	807	130

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INVENTORY - Services Data

Area	Location		Name of Facility	Diagnostic & Evaluation Clinic	Day Facility						Residential Facility					
	City or Town	County			Total Number Served	Average Daily Case Load in Services					Total Number Served	Average Daily Case Load in Services				
				Total Number Served	Total	Treatment	Education	Training	Custodial Care	Sheltered Workshop	Total	Treatment	Education	Training	Custodial Care	Sheltered Workshop
1	2a	2b	2c	3	4a	4b	4c	4d	4e	4f	5a	5b	5c	5d	5e	5f
Kauai	Hanapepe	Kauai	Child Tr. Cr.		7			7	7							
"	Kapaa	"	Child Dev. Cr.		10			10	10							
"	Kealia	"	Samuel Mahelona Mem. Hosp.								9	9		9	9	5
"	Lihue	"	Child Dev. Cl.	18*												
"	Wailua	"	Rehabilitation Unlimited, Kauai		31				31	31						
			KAUAI COUNTY TOTALS	18	48			17	43	31	9	9		9	9	5

*Also receiving services were 10 others diagnosed "Not M.R." - Lihue

CODE SHEET - SUMMARY AND PROGRAMING DATA REPORT

The following information clarifies the codes used in Forms PHS 4774-3, found on the next five pages.

General: For each city or town recorded on Form PHS 4774-1, a summarization of existing facilities and services should be entered in the appropriate columns. Similarly, information should be recorded by city or town, for additional facilities and services programed within a four year period. Thus, the data will be grouped so as to reveal the total mental retardation construction program within a particular city or town.

Existing Facilities or Programed Facilities

5. Number of existing facilities are represented in their appropriate columns by the following code letters:

A. Diagnostic and evaluation clinic
B. Day facility
C. Residential facility

6a-f. Number of existing facilities providing each of the specified services.

7a-d. Number of existing facilities serving the specified levels of retardation.

8a-c. Number of existing facilities serving specified age groupings.

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SUMMARY AND PROGRAMING DATA REPORT

Area	City or Town	County	Existing Facilities	Programed Facilities	Number of Facilities	Number and Type of Facility			Services Offered (Enter Number)						Level of Retardation Served (Enter No.)				Age Grouping Served (Enter No.)			Total Number of Mentally Retarded Served
						D & E	Day Care	Res.	Diagnostic & Evaluation	Treatment	Education	Training	Custodial Care	Sheltered Workshop	Mild	Moderate	Severe	Profound	Pre-School	School Age	Adult	
1	2a	2b	3a	3b	4	5a	5b	5c	6a	6b	6c	6d	6e	6f	7a	7b	7c	7d	8a	8b	8c	9
Hawaii	Hilo	Hawaii	E		3	1	2		1		2	2	2	1	3	3	3	1	2	3	1	97
"	Honokaa	"	E		2	1	1		1			1	1	1	2	1	2		1	2	1	17
"	Kealakekua	"	E		2	1	1		1		1	1	2		2	2			1	2	1	37
HAWAII COUNTY EXISTING TOTALS					7	3	4		3		3	4	5	2	7	6	5	1	4	7	3	151
Hawaii	Hilo	Hawaii		P	X		X			X	X	X	X	X	X	X	X	X	X	X	X	70
"	"	"		P	X			X		X		X	X	X		X	X	X	X	X	X	40
"	Kealakekua	"		P	X		X			X	X	X	X	X	X	X	X	X	X	X	X	20
HAWAII COUNTY PROGRAMED TOTALS					3		2	1		3	2	3	3	3	2	3	3	3	3	3	3	130

(See map on page 30)

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SUMMARY AND PROGRAMING DATA REPORT

Area	City or Town	County	Existing Facilities	Programed Facilities	Number of Facilities	Number and Type of Facility			Services Offered (Enter Number)						Level of Retardation Served (Enter No.)				Age Grouping Served (Enter No.)			Total Number of Mentally Retarded Served
						D & E	Day Care	Res.	Diagnostic & Evaluation	Treatment	Education	Training	Custodial Care	Sheltered Workshop	Mild	Moderate	Severe	Profound	Pre-School	School Age	Adult	
1	2a	2b	3a	3b	4	5a	5b	5c	6a	6b	6c	6d	6e	6f	7a	7b	7c	7d	8 a	8b	8c	9
Maui	Kahului	Maui	E		1		1					1	1	1	1	1				1	1	31
"	Kaunakakai	"	E		2	1	1		1			1	1		1	1	1			2		9
"	Puunene	"	E		1		1					1	1		1	1	1			1		9
"	Wailuku	"	E		2	1	1		1				1		1	2	2		1	1	1	15
MAUI COUNTY EXISTING TOTALS					6	2	4		2			3	4	1	4	5	4		1	5	2	55
Maui	Wailuku	Maui		P	X		X				X	X	X	X	X	X	X	X	X	X	X	50
"	"	"		P	X			X		X		X	X		X	X	X	X	X	X	X	40
MAUI COUNTY PROGRAMED TOTALS					2		1	1		1	1	2	2	1	2	2	2	2	2	2	2	90

(See map on page 31)

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Mental Retardation Facilities Construction Program

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SUMMARY AND PROGRAMING DATA REPORT

Area	City or Town	County	Existing Facilities	Programed Facilities	Number of Facilities	Number and Type of Facility			Services Offered (Enter Number)						Level of Retardation Served (Enter No.)				Age Grouping Served (Enter No.)			Total Number of Mentally Retarded Served
						D & E	Day Care	Res.	Diagnostic & Evaluation	Treatment	Education	Training	Custodial Care	Sheltered Workshop	Mild	Moderate	Severe	Profound	Preschool	School Age	Adult	
1	2a	2b	3a	3b	4	5a	5b	5c	6a	6b	6c	6d	6e	6f	7a	7b	7c	7d	8a	8b	8c	9
Honolulu	Honolulu	Honolulu	E		10	2	7	1	2	1	3	8	8	2	9	10	8	6	7	10	5	670
HONOLULU PLANNING AREA TOTALS					10	2	7	1	2	1	3	8	8	2	9	10	8	6	7	10	5	670
Leeward	Aiea	Honolulu	E		1		1				1	1	1		1	1	1	1		1		27
"	Pearl City		E		2		1	1		1	1	2	2	1	1	1	1	1	1	1	1	798
"	Wahiawa	"	E		2		2				1	2	2		1	2	1		1	1		20
"	Waianae	"	E		1		1					1	1		1	1	1		1	1		7
LEEWARD PLANNING AREA TOTALS					6		5	1		1	3	6	6	1	4	5	4	2	3	4	1	852
Windward	Kailua	Honolulu	E		2		2				1	2	2		2	2			1	2	1	29
WINDWARD PLANNING AREA TOTALS					2		2				1	2	2		2	2			1	2	1	29
ISLAND OF OAHU TOTAL EXISTING					18	2	14	2	2	2	7	16	16	3	15	17	12	8	11	16	7	1551

(See map on page 32)

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SUMMARY AND PROGRAMING DATA REPORT

Area	City or Town	County	Existing Facilities	Programed Facilities	Number of Facilities	Number and Type of Facility			Services Offered (Enter Number)						Level of Retardation Served (Enter No.)				Age Grouping Served (Enter No.)			Total Number of Mentally Retarded Served
						D & E	Day Care	Res.	Diagnostic & Evaluation	Treatment	Education	Training	Custodial Care	Sheltered Workshop	Mild	Moderate	Severe	Profound	Pre-School	School Age	Adult	
1	2a	2b	3a	3b	4	5a	5b	5c	6a	6b	6c	6d	6e	6f	7a	7b	7c	7d	8a	8b	8c	9
Honolulu	Honolulu	Honolulu		P	X	X			X						X	X	X	X	X	X	X	300
"	"	"		P	X		X				X	X	X		X	X	X		X	X		150
"	"	"		P	X		X				X	X	X		X	X			X	X		50
"	"	"		P	X			X		X		X	X				X	X	X	X	X	50
HONOLULU PLANNING AREA TOTALS					4	1	2	1	1	1	2	3	3		3	3	3	2	4	4	2	550
Leeward	Pearl City	Honolulu		P	X			X		X	X	X	X		X	X	X	X	X	X	X	85
"	" "	"		P	X			X		X	X	X	X		X	X	X	X	X	X	X	50
"	Wahiawa	"		P	X		X			X	X	X	X	X	X	X			X	X	X	75
LEEWARD PLANNING AREA TOTALS					3		1	2		3	3	3	3	1	3	3	2	2	3	3	3	210
Windward	Kailua	Honolulu		P	X		X	X			X	X	X	X	X	X	X		X	X		155
WINDWARD PLANNING AREA TOTALS					1		1	1			1	1	1	1	1	1	1		1	1		155
ISLAND OF OAHU TOTAL PROGRAMED					8	1	4	4	1	4	6	7	7	2	7	7	6	4	8	8	5	915

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STATE PLAN
Mental Retardation Facilities Construction Program

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SUMMARY AND PROGRAMING DATA REPORT

Area	City or Town	County	Existing Facilities	Programed Facilities	Number of Facilities	Number and Type of Facility			Services Offered (Enter Number)						Level of Retardation Served (Enter No.)				Age Grouping Served (Enter No.)			Total Number of Mentally Retarded Served
						D & E	Day Care	Res.	Diagnostic & Evaluation	Treatment	Education	Training	Custodial Care	Sheltered Workshop	Mild	Moderate	Severe	Profound	Pre-School	School Age	Adult	
1	2a	2b	3a	3b	4	5a	5b	5c	6a	6b	6c	6d	6e	6f	7a	7b	7c	7d	8a	8b	8c	9
Kauai	Hanapepe	Kauai	E		1		1					1	1			1				1		7
"	Kapaa	"	E		1		1					1	1		1	1	1			1	1	10
"	Kealia	"	E		1			1		1		1	1	1	1	1	1			1	1	9
"	Lihue	"	E		1	1			1						1	1	1		1	1		18
"	Wailua	"	E		1		1					1	1	1	1	1	1			1	1	31
KAUAI COUNTY EXISTING TOTALS					5	1	3	1	1	1		4	4	2	4	5	4		2	5	3	75
Kauai	Lihue	Kauai		P	X		X				X	X	X	X	X	X			X	X	X	60
"	"	"		P	X			X		X		X	X				X	X	X	X	X	40
KAUAI COUNTY PROGRAMED TOTALS					2		1	1		1	1	2	2	1	1	1	1	1	2	2	2	100

(See map on page 33)

DIAGNOSTIC AND EVALUATION CENTERS

Approximately 290 retardates are added to the State's population each year with 85% of these on the Island of Oahu. This estimate is based on the number of annual births although their diagnosis is usually conducted at about 3 or 4 years of age. Diagnostic and evaluation facilities can serve from 150 to 300 annual cases. At this rate one D & E center is ample to serve the needs of the entire State.

Oahu is the only area in the State with a large enough concentration of population to support the more sophisticated and specialized services and programs necessary to provide a full range of services needed for comprehensive diagnosis and evaluation. Honolulu with its large hospitals and the University of Hawaii would be the natural center for such activity.

To avoid costly duplication of facilities, services, and the specialized manpower needs, a diagnositc and evaluation center should be built in connection to an existing medical facility. The diagnostic and evaluation center should provide only that service that is unique for work with the mentally retarded or is not already available at the existing medical facility.

Preliminary diagnostic, evaluation and screening services are available on a scheduled periodic itinerant basis throughout the rural areas and communities on the Neighbor Islands as well as in rural Oahu. These itinerant clinics can offer the first and most important step in the care of the retarded. Those needing continued services should be referred by the clinic or a private physician to a specialized diagnostic and evaluation center in metropolitan Honolulu.

None of the Neighbor Islands has an estimated caseload large enough to meet the minimum requirement of 150 annual cases for starting a new center.

Planning for more than one well-staffed center at the beginning of a program could possibly endanger or fragment services to the detriment of progressive program development. Annual review, evaluation and revision of planning based on new developments will provide guides and statistics as a basis for development of another comprehensive diagnostic and evaluation center in the future.

Summary by Area and Degree of
Hawaii's Projected Numbers of Mentally Retarded - 1974

Area	Mild	Moderate	Severe	Profound	Total
Hawaii	1,264	85	50	21	1,420
Maui	926	62	36	16	1,040
Honolulu	6,675	450	263	113	7,500
Leeward	2,744	185	108	46	3,083
Windward	1,763	119	69	30	1,977
Kauai	605	41	24	10	680
State	13,973	942	550	235	15,700

DAY CARE CENTERS

The following table shows the number of clients from the projection summary (page 42) who are likely candidates for day care centers. Although most of the mildly retarded under age 20 should be in special education classes in the public schools, it is estimated that 5% will need some additional services, such as counseling or work training.

It is further estimated that 45% of the moderately retarded might enroll in day centers for training. (Thirty-two percent are in the public school system and another 20% are institutionalized at Waimano.)

The percentages above, when applied to the foregoing table, estimate the potential caseloads for day centers.

Day Care Centers - Estimated Caseloads - 1974

Service Area	5% of Mildly Retarded	45% of Moderate	10% of Severe	Estimated Caseload	Caseload per Center		No. Centers Needed
					Max.	Min.	
Hawaii	63	38	5	106	200	40	1
Maui	46	28	4	78	200	40	1
Honolulu	334	203	26	563	200	40	3
Leeward	137	83	11	231	200	40	2
Windward	88	54	7	149	200	40	1
Kauai	30	18	2	50	200	40	1
State	699	424	55	1,178			9

With their attendant services of treatment, education, training, custodial care, or sheltered workshops, the day care facilities are needed in all areas in the State. Definitive planning for combination or separation of specific services can be made after more adequate experience is gained in their operation.

Where splintering of services does occur between facilities, arrangements shall be made for transfers of necessary patient information and progress notes. Such transfers of information will be accomplished in a manner that no administrative blocks will occur in the orderly development of the treatment, evaluation or work program of the patient involved. Transfer arrangements will also be developed between diagnostic and evaluation facilities and/or day care facilities and/or residential facilities as necessary to carry out the patient's program activity in the same fashion and to accomplish the same goals.

Day care facilities are specifically planned for Honokaa and Kona on the Island of Hawaii because of travel time to Hilo, the Island's principal city. Facilities for the other planning areas should be planned in the population centers.

Construction of Honokaa's new Brantley Center will begin in September, 1969. The Center will offer day care and work training to handicapped clients including the mentally retarded.

RESIDENTIAL CENTERS

In 1965, only 63% of the State's known mild retardates were being served on Oahu, while 83% of the moderate, 94% of the severe and 100% of the known profoundly retarded clients were receiving specialized services on Oahu. These figures suggest that the more devastated cases may be gathering at Waimano Training School and Hospital which is the State's only institutional facility for the mentally retarded.

Projection of need for residential facilities is based on caseloads with a minimum of 40 and a maximum of 500, as shown in the following table. Percentages refer to summary of projected M.R.'s on page 66.

M.R. Residential Facilities - Estimated Caseloads - 1974

Service Area	1% of Mild	25% of Moderate	80% of Severe	100% of Profound	Total	No. of Centers Needed
Hawaii	13	21	40	21	95	1
Maui	9	15	29	16	69	1
Honolulu	67	113	210	112	502	1
Leeward	27	46	86	46	205	1
Windward	18	30	55	30	133	1
Kauai	6	10	19	10	45	1
State	140	235	439	235	1,049	6

It should be emphasized that the foregoing table indicates the number of residential centers needed by the populations of the service areas. These services, however, need not necessarily be located within those areas. Institutional services such as Waimano Training School and Hospital serve a Statewide need and therefore reduce the demand for services within the individual areas. The residential needs are somewhat different for each area and vary from foster home arrangements to actual boarding homes where clients might live part-time (such as 5 days per week; going home weekends) and attend community work-training programs during the day. Transportation problems strengthen the desirability of this idea.

Planned for all areas in the State are residential facilities with their attendant services of treatment, education, training, custodial care, or sheltered workshops. When more adequate experience is gained in the operation of decentralized residential facilities, and the compatibility of services tested, definitive planning for combination or separation of specific services can be made.

Arrangements shall be made when necessary for transfer of patient information and progress notes in such a manner that no administrative blocks will occur in the orderly development of the treatment, evaluation or work program of the patient involved.

WAIMANO TRAINING SCHOOL AND HOSPITAL

The principal resource for the care and treatment of the mentally retarded for the State of Hawaii is Waimano Training School and Hospital. New developments which have focused attention on the mentally retarded should bring to Waimano the much needed community assistance and support to meet the needs of its 800 clients.

New program development at the facility has been taking place especially in the area of training and release of patients on a community placement program. Change is often a painful process which brings unexpected problems, requiring the constant awareness of the staff.

Until decentralized residential care facilities can be developed, Waimano remains the only major facility providing this service. Continued efforts are made to improve staffing ratios and the quality of personnel, increase the day care activities, replace the nonconforming areas, and stimulate dynamic program development.

With consideration for Hawaii's population growth and the duration of time required to plan and construct a decentralized system of residential facilities, priority will be given to the needs at Waimano for basic, safe facilities. The possible future role of Waimano is that of caring for those retardates in need of total care, the profound, and a portion of the severely retarded. Such a facility should provide adequate functional space for each patient and would require all the building space now available and currently planned. (See also Waimano in Appendix)

REVIEW OF PROGRAMED FACILITIES

Planning Area	Number of Facilities			Planned Caseload
	D & E	Day Care	Res.	
Hawaii	0	1-Hilo 3 (1-Kona) 1-Honokaa	1	130
Maui	0	1	1	90
Honolulu	1	3	1	550
Leeward	0	2	2	210
Windward	0	1	1	150
Kauai	0	1	1	100
Total	1	11	7	1,235

ANALYSIS OF PROGRAMED FACILITIES

Services are the foundation of program development. The fact that these services must be housed is a matter of concern in this document. It reflects that an attempt to install necessary services within an existing building may be influenced disproportionately by the building itself. This could limit or exaggerate the program development or influence its direction.

Ideally, the services should be developed through careful planning. The design of the facility to house these services should reflect the function of the service in the most flexible manner to allow for growth and change. Planning for the mentally retarded program must follow this basic concept. Although consideration appears to focus on the facility and the funds for construction, the guiding principal must be the applying of goals and the implementation of programs for the mentally retarded.

The need in the state as shown by the Comprehensive Mental Retardation Plan is for coordination and development of community service centers that can form the basic component for keeping communication systems open and informing the public, assisting in development of resources, conducting demonstration projects and providing basic data suggesting need for new programs.

These community service centers may conduct active programs for the mentally retarded or they may simply coordinate various resources.

DETERMINATION OF SERVICE AREA PRIORITIES

Priorities for new facilities are based on the following indices: estimated M.R. births by service areas; waiting lists of M.R.'s in public schools; enrollments in M.R. facilities by service areas.

Difficulty in obtaining adequate detail in statistical data has made it cumbersome to show consistent relationships of needs in the six service areas. The following tables represent only a portion of the entire picture; however, they cover a broad area of sampling which has been carefully studied and evaluated.

Estimated M.R. Births* by Service Areas - 1968

Service Area	Estimated No. M.R. Births	Rate per 10,000 Population	Order of Greatest Need
Hawaii	19	2.9	6
Maui	16	3.3	4
Honolulu (Oahu)	145	4.2	1**
Leeward (Oahu)	60	4.2	3**
Windward (Oahu)	39	4.2	2**
Kauai	10	3.2	5

*Relates to table on page 41.

**On Oahu, where detailed breakdowns were not available by service areas, it was assumed that the greatest need for services existed in the area of highest population density per square mile.

Public Schools - M.R. Enrollments & Waiting Lists
1968-69

Service Area	Total Enrolled Plus Waiting	M.R.'s Enrolled	Diagnosed M.R.'s Waiting	M.R.'s Waiting (Rate per 1,000 pop.)	Order of Greatest Need
Hawaii	458	395	63	0.96	3
Maui	222	165	57	1.18	1
Honolulu	803	713	85	0.24	5
Leeward	841	697	144	1.01	2
Windward	322	287	35	0.38	4
Kauai	146	141	5	0.16	6
Total	2,792	2,403	389		

The order of greatest need in the previous table is determined by the ratio of "M.R.'s waiting for special classes" to the population of the service area.

New services are known to attract new patients or clients, but the demand for these new services is difficult to assess in advance. Statistical records, unfortunately, carry only figures of "known" clients. These figures, however large and impressive they may be, do not determine additional need.

In the table below, the "order of greatest unmet need" was determined by comparison with the factor of 2.0% of total population, or 20 clients per 1,000 population. The area of greatest unmet need is the area whose rate per 1,000 population falls farthest below the number 20 (per thousand).

Enrollments in Mental Retardation Facilities - 1968
(Other than Public Schools)

Service Area	Number Of Clients	Rate per 1,000 Population	Order of Greatest Unmet Need
Hawaii	268	4.07	6
Maui	137	2.84	4
Honolulu)	1,315	2.23	1
Leeward)			3
Windward)			2
Kauai	121	3.88	5
Total	1,841		

In this table, the clients from Waimano Training School and Hospital are counted with their home counties, even though they receive services in the Leeward area. This table should be compared with the one on page 36, which lists Waimano residents as Honolulu County enrollments.

The number of other clients receiving M.R. services outside their own areas is not known. Especially on Oahu, the number is assumed to be high enough to distort individual service area figures as many Leeward and Windward clients attend centers in Honolulu.

A summary of these three tables will serve as the basis for forming priorities among service areas within Hawaii State for construction of facilities for the mentally retarded.

Summary of Tables Determining Greatest Need*

Service Area	M.R. Births	Waiting for Schools	M.R. Facilities Enrollments	Total	Final Order
Hawaii	6	3	6	15	4
Maui	4	1	4	9	3
Honolulu	1	5	1	7	1
Leeward	3	2	3	8	2
Windward	2	4	2	8	2
Kauai	5	6	5	16	5

*This summary table uses only the "Order of Greatest Need" column from each of the three foregoing tables.

By adding the orders of need established from data within the foregoing tables, the service area with the lowest total is awarded first priority in the final order. The summary table yields the following order of priorities for fiscal year 1969-70.

No. 1 - Honolulu

2 & 3 - Tie: Leeward, Windward

4 - Kauai

*5 & 6 - Hawaii, Maui

*Hawaii and Maui were both recipients of 1969 M.R. Construction grant and must therefore be placed last among the 1970 priorities. Kauai, therefore, becomes fourth in area priorities, rather than last place as shown in the table on this page.

. . . APPENDIX

. . . METHODS OF ADMINISTRATION

. . . REVISED LAWS OF HAWAII

. . . SPECIAL PROJECTS

Mental Retardation

Dental Program

Phenylketonuria Testing

Waimano Training School and Hospital

METHODS OF ADMINISTRATION

Publicizing the Plan

A general description of the provisions of the proposed State Plan appeared in the Honolulu Advertiser and Honolulu Star Bulletin, Ltd., on OCT 31 1969 Both newspapers have state-wide circulation.

The State Plan is available at all times in the Hospital and Medical Facilities Branch for examination by interested persons.

Project Construction Schedule

After approval of the State Plan by the Social and Rehabilitation Service, the State Agency will develop a Project Construction Schedule which will list the projects for which construction can be started immediately. The Schedule will be developed by soliciting applications from sponsoring agencies in areas of unfilled need and in the order of the area priorities as shown in the over-all construction program. The number of projects included on the Project Construction Schedule will depend upon the amount of the Federal allotment to the State.

After approval of the Schedule by the Social and Rehabilitation Service, a project should not be removed therefrom except when an applicant must be dropped by reason of his:

(1) Failure to submit required documents;

(2) Failure to comply with prescribed rules and regulations, such as inability to meet the financial requirements or failure to prepare plans and specifications; or

(3) Voluntary withdrawal.

If a project is removed from the Project Construction Schedule by the State Agency, the Schedule will be revised to include the next highest priority project which meets the requirements for inclusion.

The first Project Construction Schedule will be submitted to the Regional Office of the Social and Rehabilitation Service as soon as practicable after allocation of funds.

Standards of Construction and Equipment

Construction and equipping of projects assisted under the program shall comply with the general standards of construction and equipment adopted by the State Agency which are the minimum general standards of the Public Health Service.

Inspection Procedures

When a request for an installment payment is made, the State Agency will make an inspection of the project to determine that services have been rendered, work has been performed and purchases have been made as determined by the inspection, and in accordance with the approved project application. In addition, the State Agency will make such additional inspections as are deemed necessary. Reports of each inspection will be retained in the files by the State Agency.

Construction Payments

Requests for construction payments shall be submitted by applicants to the State Agency who shall prepare requests certifying to the Commissioner, Social and Rehabilitation Service, the amount of payments due an applicant for the cost of work performed and materials and equipment furnished. Requests for payments under construction shall, in general, be submitted in each of the following stages:

(1) The first installment when not less than 25% of the construction of the project has been completed;

(2) A second installment when not less than 50% of the construction of the project has been completed;

(3) A third installment when not less than 75% of the construction of the project has been completed;

(4) A fourth installment when the project is 95% completed;

(5) Final payment when the project is completed and final inspection by representative of the Commissioner, Social and Rehabilitation Service, is made in the amount certified as due and payable as determined by the audit.

Personnel Standards

Merit System:

Personnel employed in the administration of the State Plan are appointed in accordance with provisions of the Civil Service Commission, State of Hawaii. The Commission provides for: impartial administration of the merit system operation on the basis of published rules; appropriate classification of all positions; compensation schedules adjusted to the responsibility and difficulty of the work; selection of permanent appointees on the basis of competitive examinations; advancement on the basis of capacity and meritorius service; and tenure of permanent employees in compliance with the merit system policies of the Public Health Service.

The Civil Service Commission will supply, upon request, the Social and Rehabilitation Service with such data and information as is necessary to determine compliance with the Act and Regulations.

Financial Records

State Agency will comply with the provisions of Section 54.116 of the Regulations by maintaining the necessary accounting records and controls, and requiring applicants for federal funds to maintain adequate fiscal records and controls.

The State Agency agrees that it will retain on file all documents coming into its possession which relate to any expenditure under P.L. 88-164. In addition, the State Agency will take such steps as are necessary to assure that applicants:

(1) Retain all relevant and supporting documents; and

(2) Establish suitable property inventory records covering all equipment of more than nominal value.

The State Agency further agrees that it will:

(1) Retain the accounting records, controls and documents described in "A" and "B" above for a period of at least five years after final payment or until a Federal audit is completed, whichever is earlier.

(2) Take such steps as are necessary to assure that applicants retain the fiscal records, controls, and documents described in "A" and "B" above for a period of at least three years after the final payment of federal funds.

Federal Share

The State policy of percentage of participation in projects for the construction of facilities for the mentally retarded recommended by the State Advisory Council on Hospitals and Medical Facilities will be a maximum of 46% for all eligible costs in each approved project for fiscal year beginning July 1, 1968, and ending June 30, 1969.

Minimum Standards of Maintenance and Operation

Facilities constructed under this program shall comply with the minimum standards of maintenance and operation as developed for the specific type of occupancy which the facilities serve. Such standards are: currently existing public health regulations pertaining to housing, care homes, nursing and convalescent homes, hospitals, environmental sanitation etc. (Chapters 12, 12A, and 12B, of Public Health Regulations, Department of Health, State of Hawaii, and the State Fire Marshal's code.) All of the environmental standards of the Department of Health would also apply in a general way as would all regulations on handling drugs, poisons, or food products. Chapter 24, Working Places and Conditions, would also relate in a general way. Beyond this, facilities must meet the county and other local jurisdictional codes that are enforced in the specific county where the facility is constructed.

Fair Hearings

Any applicant who has made request for Federal assistance in construction and is dissatisfied with the action taken by the State Agency will have the opportunity for a fair hearing. The Agency's action which entitles the applicant to a fair hearing are:

(1) Denial of opportunity to make formal applications;

(2) Rejection or disapproval of application;

(3) Refusal to reconsider applications.

The appeals from the decision or decisions made by the State Agency shall be made, in writing, by the applicant within 15 days following adverse decision regarding participation in the construction program. The applicant will be notified in writing of the time and place of hearing; he will be entitled representation of his choice and all evidence will be placed at his disposal for examination. The final decision of the State Agency will be made, in writing, 15 days from the date of hearing.

Submission of Reports and Accessibility of Records

The State Agency agrees to make records accessible to the Secretary, Department of Health, Education, and welfare, and the Comptroller General or their representatives for purposes of examination.

Assurances of Nondiscrimination

No application for construction in any of the categories will be approved under this plan unless applicant includes therein the following statement:

"The applicant hereby gives assurance to the State Agency that all portions and services of the entire facility for the construction of which, or in connection with which, aid under the Federal Act is sought, will be made available without discrimination on account of race, creed, or color, or national origin; and that no professionally qualified person will be discriminated against on account of race, creed, color or national origin with respect to the privilege of professional practice in the facility."

The State Agency further certifies:

"The State Agency hereby certifies that the applicant has given adequate assurance that the facility will be operated without discrimination because of race, creed, or color in accordance with the above statement."

Assurances of Those Unable to Pay

Facilities constructed under this program will furnish below cost or without charge a reasonable volume of services to persons unable to pay therefor. As used in this paragraph, "persons unable to pay therefor" includes both the legally indigent and persons who are otherwise self-supporting but are unable to pay the full cost of needed services. Such services may be paid wholly or partly out of public funds or contributions of individuals and private and charitable organizations such as the Community Chest or may be contributed as an expense of the facility for the mentally retarded itself. In determining what constitutes a reasonable volume of services to persons unable to pay therefor, there shall be considered conditions in the area to be served by the applicant including the amount of such service as may be available otherwise than through the applicant. The requirement of assurance from the applicant may be waived if the applicant demonstrates to the satisfaction of the Department of Health subject to subsequent approval by the Commissioner, Social and Rehabilitation Service, that to furnish such services is not feasible financially.

Transfer of Allotments

Transfer of allotment to another State: A State may submit a request in writing to the Commissioner, Social and Rehabilitation Service, that its allotment or a specified portion thereof be added to the allotment of another State for the purpose of meeting a portion of the Federal share of the cost of a project for the construction of a facility for the mentally retarded in such other State. In determining whether the facility with respect to which the request is made will meet the needs of the State making the request and that use of the specified portion of such State's allotment, as requested by it, will assist in carrying out the purposes of Part C of Title I of the Act, the Commissioner, Social and Rehabilitation Service, shall consider the accessibility of the facility, and the extent to which services will be made available to the residents of the State making the request.

Transfer of allotment to the allotment for community mental health facilities: A State may submit a request in writing to the Commissioner, Social and Rehabilitation Service, that a specified portion of its allotment be added to the allotment to such State under Title II of the Act for the construction of community mental health centers. The Commissioner, Social and Rehabilitation Service, shall adjust the allotments of such State upon either:

(1) Certification by the State Agency that it has afforded from the date of availability of the first such allotment to the State a minimum of 18 months (but not exceeding the period of availability under the Act), and for any subsequent allotment to such State a minimum of 6 months, during which application could be made for the portion so specified and that no approvable applications for such funds were received during that period of time; or

(2) A demonstration satisfactory to the Commissioner, Social and Rehabilitation Service, that the need for community mental health centers is substantially greater than for facilities for the mentally retarded, such demonstration to include the concurrence or other views of the State advisory council designated under section 134 (a) (3) of Title I, Part C of the Act.

Conflict of Interest

No full-time officer or employee of the State Agency, or any firm, organization, corporation, or partnership which such officer or employee owns, controls, or directs, shall receive funds from the applicant, directly or indirectly, in payment for services provided in connection with the planning, designing, constructing or equipping of the project.

Construction of Schools for the Mentally Retarded

Projects for the construction of a facility housing educational services for school age children are limited to facilities providing services to those who are unable to participate in public schools due to particular circumstances. Among these circumstances are associated handicapping conditions such as physical handicaps and emotional disturbance.

Eligibility of a project requesting Federal assistance for the construction of a facility to house educational services or training services would depend, among other things, upon three factors. First, the services to be provided in the proposed facility must come within the scope of the definition of educational services as contained in Section 54.104 of the Regulations. Second, the services must be programed in the approved State Plan for the geographical area to be served by the project. Finally, the applicant must be either a public or nonprofit organization or agency. Eligibility would not be affected by staffing from the public school instructional staff.

CHAPTER 48A

REVISED LAWS OF HAWAII
HOSPITAL AND MEDICAL FACILITIES CONSTRUCTION

48A-1. TITLE. This chapter may be cited as the "State Hospital and Medical Facilities Survey and Construction Act." [L. 1957, c. 59, pt. of s. 1.]

48A-2. DEFINITIONS. As used in this chapter:

(a) ["Department"] means the [department] of health of the State.

(b) "The Federal Act" means Title VI of the Public Health Service Act (42 U.S.C. 291 et seq.) as now and hereafter amended. [Amended S.L. 1964]

(c) "The surgeon general" means the surgeon general of the United States Public Health Service.

(d) "Hospital" includes public health centers and general, tuberculosis, mental, chronic disease, and other types of hospitals, and related facilities, such as laboratories, out-patient departments, nurses' home and training facilities, and central service facilities operated in connection with hospitals, but does not include any hospital furnishing primarily domiciliary care.

(e) "Public health center" means a publicly owned facility for the provision of public health services, including related facilities such as laboratories, clinics, and administrative offices operated in connection with public health centers.

(f) "Nonprofit hospital" and "nonprofit medical facility" mean any hospital or medical facility owned and operated by one or more nonprofit corporations or associations, no part of the net earnings or which inures, or may lawfully inure, to the benefit of any private shareholder or individual.

(g) "Medical facilities" means diagnostic or diagnostic and treatment centers, rehabilitation facilities and nursing homes as those terms are defined in the Federal Act, and such other medical facilities for which federal aid may be authorized under the Federal Act.

(h) "Division" means the division of hospitals and medical care of the board of health.

(i) "Fund" means the hospital and medical facilities fund established by this chapter.

(j) "Commission" means the state advisory commission for hospitals and medical care. [L. 1957, c. 59, pt. of s. 1.]

48A-3. ADMINISTRATION; DIVISION OF HOSPITALS AND MEDICAL CARE. The [department] shall constitute the sole agency of the State for the purpose of:

(a) Making an inventory of existing hospitals and medical facilities, surveying the need for construction of hospitals and medical facilities, and developing a program of construction as provided in this chapter; and

(b) Developing and administering a state plan for the construction of public and other nonprofit hospitals and medical facilities as provided in this chapter. [L. 1957, c. 59, pt. of s. 1.] [48A-3.1 see Amendment S.L. 1964, Act 14]

48A-4. GENERAL POWERS AND DUTIES. In carrying out the purposes of this chapter, the [department] is authorized and directed to:

(a) Require such reports, make such inspections and investigations and prescribe such rules and regulations as are deemed necessary; administrative rules and regulations shall be excepted from the operation of section 7-30;

(b) Provide such methods of administration, appoint a director and other personnel and take such other action as may be necessary to comply with the requirements of the Federal Act and the regulations thereunder;

(c) Procure in its discretion the temporary or intermittent services of experts or consultants or organizations thereof, by contract, when such services are to be performed on a part-time or fee-for-service basis and do not involve the performance of administrative duties;

(d) To the extent that it considers desirable to effectuate the purposes of this chapter, enter into agreements for the utilization of the facilities and services of other departments, agencies, institutions, public or private;

(e) Accept on behalf of the State and deposit with the state /director of finance/ any grant, gift or contribution made to assist in meeting the cost of carrying out the purposes of this chapter, and upon warrants of the comptroller, based on vouchers of the /department/, expend the same for such purposes;

(f) Make an annual report to the governor on activities and expenditures pursuant to this chapter, including recommendations for such additional legislation as the /department/ considers appropriate to furnish adequate hospital and medical facilities to the people of this State;

(g) Do all other things on behalf of the State necessary to obtain full benefits under the Federal Act. /L. 1957, c. 59, pt. of s. 1 and c. 152, s. 1./

48A-5. ADVICE AND ASSISTANCE. The /department shall receive the advice and assistance of the state commission for hospitals and medical care in discharging its duties and exercising its powers under this chapter. Such advisory commission shall meet as often as the /department/ deems necessary, but not less than once each year. /L. 1957, c. 59, pt. of s. 1./

48A-6. SURVEY AND PLANNING ACTIVITIES. The /department/ is authorized and directed to make an inventory of existing hospitals and medical facilities, including public, nonprofit and proprietary hospitals and medical facilities, survey the need for construction of hospitals and medical facilities and, on the basis of such inventory and survey, develop a program for the construction of such public and other nonprofit hospitals and medical facilities as will, in conjunction with existing facilities, afford the necessary physical facilities for furnishing adequate hospital and medical facility services to all the people of the State. /L. 1957, c. 59, pt. of s. 1./

48A-7. CONSTRUCTION PROGRAM. The construction program shall provide, in accordance with regulations prescribed under the Federal Act, for adequate hospital and medical facilities for the people residing in the State and insofar as possible shall provide for their distribution throughout the State in such manner as to make all types of hospital and medical facility services reasonably accessible to all persons in the State. /L. 1957, c. 59, pt. of s.1./

48A-8. APPLICATION FOR FEDERAL FUNDS FOR SURVEY AND PLANNING; EXPENDITURE. The /department/ is authorized to make application to the surgeon general for federal funds to assist in carrying out the survey and planning activities herein provided. Such funds shall be deposited in the state treasury and shall be available to the [department] upon warrants issued by the comptroller based on vouchers of the [department] for expenditure for the survey and planning program. Any such funds received and not expended for such purposes shall be repaid to the treasury of the United States. [L. 1957, c. 59, pt. of s. 1 and c. 152, s. 1.]

48A-9. STATE PLAN. The [department] shall prepare and submit to the surgeon general a state plan which shall include the hospital and medical facilities construction program developed under this chapter and which shall provide for the establishment, administration and operation of hospital and medical facilities construction activities in accordance with the requirements of the Federal Act and regulations thereunder. The [department] shall, prior to the submission of such plan to the surgeon general, give adequate publicity to a general description of all the provisions proposed to be included therein. After approval of the plan by the surgeon general, the [department] shall make the plan, or a copy thereof, available upon request to all interested persons or organizations. The [department] shall from time to time review the construction program and submit to the surgeon general any modifications thereof which it may find necessary and may submit to the surgeon general such modifications of the state plan, not inconsistent with the requirements of the Federal Act, as it may deem advisable. [L. 1957, c. 59, pt. of s. 1.]

48A-10. MINIMUM STANDARDS FOR HOSPITAL AND MEDICAL FACILITIES maintenance and operation. The [department] shall by regulation prescribe minimum standards for the maintenance and operation of hospitals and medical facilities. [L. 1957, c. 59, pt. of s. 1.]

48A-11. PRIORITY OF PROJECTS. The state plan as established by the [department] shall set forth the relative need for the several projects included in the construction program determined in accordance with regulations prescribed pursuant to the Federal Act, and provide for the construction, insofar as financial resources available therefor and for maintenance and operation make possible, in the order of such relative need. [L. 1957, c. 59, pt. of s. 1.]

48A-12. CONSTRUCTION PROJECTS: APPLICATIONS. Applications for hospital and medical facilities construction projects for which federal funds are requested shall be submitted to the [department] and may be submitted by the State or any political subdivision thereof or by any public or other nonprofit agency authorized to construct and operate a hospital or a medical facility, provided that no application for a diagnostic or treatment center shall be approved unless the applicant is (a) the State, a political subdivision, or public agency, or (b) a corporation or association which owns and operates a nonprofit hospital. Each application for a construction project shall conform to federal and state requirements. /L. 1957, c. 59, pt. of s. 1./

48A-13. CONSIDERATION AND FORWARDING OF APPLICATIONS. The /department/ shall afford to every applicant for a construction project an opportunity for a fair hearing. If the /department/, after affording a reasonable opportunity for development and presentation of applications in the order of relative need, finds that a project application complies with the requirements of section 48A-12 and is otherwise in conformity with the state plan, it shall approve such application and shall recommend and forward it to the surgeon general. /L. 1957, c. 59, pt. of s. 1./

48A-14. INSPECTION OF PROJECTS. From time to time the /department/ shall inspect each construction project approved by the surgeon general, and, if the inspection so warrants, the /department/ shall certify to the surgeon general that work has been performed upon the project, or purchases have been made, in accordance with the approved plans and specifications, and that payment of an installment of federal funds is due to the applicant. /L. 1957, c. 59, pt. of s. 1./

48A-15. HOSPITAL AND MEDICAL FACILITIES CONSTRUCTION FUND. The /department/ may receive federal funds in behalf of, and transmit them to, such applicants. There shall be, separate and apart from all other public moneys and funds of this State, a hospital and medical facilities construction fund. Money received from the federal government for a construction project approved by the surgeon general shall be deposited to the credit of this fund and shall be used solely for payments due applicants for work performed, or purchases made, in carrying out approved projects. Vouchers for all payments from the fund shall bear the signature of the /director of health/ or his duly authorized agent for such purpose. /L. 1957, c. 59, pt. of s. 1./

48A-16. STATE ADVISORY COMMISSION FOR HOSPITALS AND MEDICAL CARE. /omitted./ /L. 1957, c. 59, pt. of s. 1./

ACT 14

A Bill for an Act to Amend the Definition of "The Federal Act" as it Appears in Chapter 48A-2, Revised Laws of Hawaii 1955, as Amended (1961 Supplement), Relating to Hospital and Medical Facilities Construction.

Be it Enacted by the Legislature of the State of Hawaii:

SECTION 1. This Act is hereby declared to be an urgency measure deemed necessary in the public interest within the meaning of section 11, Article III of the Constitution of the State of Hawaii.

The following is a statement of facts constituting such urgency:

In order to receive federal funds and to comply with federal regulations under the Mental Retardation Facilities and Community Mental Health Centers Construction Act of 1963 (Public Law 88-164), it is necessary that section 48A-2(b), Revised Laws of Hawaii 1955, as amended (1961 Supplement) be broadened to include Public Law 88-164. At present it covers only Title VI of the Public Health Service Act. Otherwise, the State would be unable to secure federal funds under the current mental retardation program. The federal government also requires that a State Agency be designated the sole agency for implementing the Mental Retardation Facilities and Community Mental Health Centers Construction Act of 1963 (Public Law 88-164).

SECTION 2. Section 48A-2(b), Revised Laws of Hawaii 1955, as amended, is hereby amended to read as follows:

"(b) 'The Federal Act' means Title VI of the Public Health Service Act (42 U.S.C. Section 291 et seq.) with respect to hospitals and medical facilities and other facilities related to each, and the Mental Retardation Facilities and Community Mental Health Centers Construction Act of 1963 (P.L. 88-164) with respect to facilities for the mentally retarded and community mental health centers, both as now and hereafter amended, or any other Act of Congress existing or hereafter enacted which relates to the planning, survey and construction of hospitals and medical facilities and other facilities related to each."

SECTION 3. Chapter 48A, Revised Laws of Hawaii 1955, as amended, is hereby amended by adding thereto a new section, to be designated section 48A-3.1, to read as follows:

"48A-3.1. The state department of health shall be the sole agency for implementing the Mental Retardation Facilities and Community Mental Health Centers Construction Act of 1963 (Public Law 88-164) or any other Act of Congress hereafter enacted which relates to the planning, survey and construction of hospitals and medical facilities and other facilities related to each."

SECTION 4. This Act shall take effect upon its approval. (Approved April 20, 1964.) S.B. 34.

MENTAL RETARDATION PROGRAM DEVELOPMENT

Continued emphasis will be given to the mental retardation program, both the institutional program at Waimano and the community service activities. Various demonstration projects, which were initiated in 1966 with State funds, will be continued; these include day care services, homemaker services, home nursing services, halfway house for girls, and an intensive training unit.

The hospital improvement and the hospital in-service training projects at Waimano are making good headway and will be continued with Federal support.

The foster grandparents project supported by the Office of Economic Opportunity is providing needed services and will be continued. Under this project, needy elderly persons are hired to provide emotional comfort to the retarded.

Financial aid to private mental retardation associations, which commenced in 1965, previously allowed an expenditure of $35 per child per month. This has now been increased to $50 per child per month. The legislature has also requested that a study be made to determine whether the training centers now run by the private associations should be taken over by official public agencies.

CHILDREN'S HEALTH SERVICES DIVISION PLAN

This Division was established on July 1, 1965 to combine several services. Until July 1965, services were carried on in the Maternal and Child Health Services Branch (of the Division of Medical Health Services), and the Community Services Branch (of the Division of Mental Retardation).

There are two Branches of the above new Division: 1) the Maternal and Child Health Branch; and 2) the Crippled Children Branch. The latter includes all of the services for mentally retarded which were formerly in the Community Services Branch (of the Division of Mental Retardation).

Reorganization was approved for the purpose of more efficient administration, and better services to children. It had become apparent since 1960 that there was some overlapping and fragmentation of staff and services between Crippled Children and the diagnostic and treatment services of the Mental Retardation Division. Under one Division, the responsibility of administration is to see that services, staff and records are well coordinated. Many children have multiple handicaps, including retardation.

Escalating funds and special project funds under the Social Security Amendments of 1963 and 1965 for programs of the Division require coordinated short-and long-range planning at the Division level.

The Division is also administering the health services throughout the State for children and youth in the programs of the Office of Economic Opportunity. Services are comprehensive and supplement existing health services of the State. Various Division staff members have contributed significant proportions of time toward administering these programs. The various screening examinations have resulted in greater demand for the diagnostic and treatment services provided by the State, because of the increased case finding.

CRIPPLED CHILDREN'S PLAN

In the organization of the Department of Health, the Crippled Children Branch is placed in the Children's Health Services Division.

A few Division staff members such as the public health administrative assistant, speech and hearing consultant, chief psychologist, medical social work consultant, and the pediatric nursing consultant have also staff and/or line responsibility in the Crippled Children Branch.

The Crippled Children Branch includes the programs formerly in the Community Services Branch of the Mental Retardation Division.

I. Significant Health Needs and Administrative Problems

A. The most important health and administrative needs relating to crippled children are as follows:

1. Mental Health Services

The Mental Health Division has augmented its services to emotionally disturbed children through the establishment of guidance clinics which include services to children. However, there are limited in-patient treatment services for disturbed children available . . . It is hoped that within the year, day care facilities (with modified treatment and educational opportunities) can be made available for less disturbed children. Plans depend upon priorities set up within the coming year for a statewide mental health plan. The staff of the Children's Health Services Division will participate in the planning operation of the Statewide Comprehensive Mental Health Program Plan.

2. Dental and Orthodontic Care

Orthodontic and restorative dental care services in Hawaii are inadequate. At present orthodontic care is available only to cleft lip and palate patients in the Crippled Children's program. Dental care is available to selected children in the Crippled Children's program. Requests are received for assistance for children with severe malocclusion, which is not associated with another defect. It would be desirable to accept such cases, the degree for which services would be rendered would be established with qualified orthodontists. No statistics are available on prevalence.

3. Convalescent Care

A facility for convalescent care for children with chronic diseases needs to be made available with an appropriate budget, and suitable residential facilities for severely handicapped young people with normal mentality are also lacking.

4. Diagnostic and treatment facilities for children handicapped with allergies need to be provided. At the present time a large number of allergic children are without continuous skilled medical help. Data to support the need may be obtained from the Hawaii Health Survey Report No. 5, 1962: "Asthma-hay fever.

This was by far the most frequent type of chronic condition reported for Oahu children and youth. It constituted about 30% of all chronic conditions reported for those under the age of 25 and affected approximately 23,000 individuals. The prevalence rate per 1,000 population was well over double a comparable rate for the Mainland as a whole."

II. Program Content

A. General

The Branch offers services to children with cleft lip and palate, cerebral palsy, rheumatic fever and rheumatic heart disease, congenital heart disease, epilepsy, orthopedic conditions, cystic fibrosis, plastic conditions requiring long-term treatment and multiple procedures, selected neurologic and urogenital abnormalities, conditions causing hearing loss, mental retardation and inborn errors of metabolism causing mental retardation. The last two represent programs incorporated from the former Mental Retardation Division making possible better coordination of services to children with both physical and intellectual handicaps. Priority is given to young children and to those children having crippling conditions requiring a team approach of medical and para-medical specialists for treatment.

Fee-for-service personnel working in the program have qualifications outlined below.

For all types of care not noted below, physicians working in the Crippled Children's program are Board-qualified (i.e., have completed the hospital training required by the Boards) or Board-certified in their respective specialty. In the case of cardiology and neurology, pediatricians and internists with experience and prior Crippled Children Branch service are used as well as sub-specialty-qualified persons. In one instance, a certified ophthalmologist with much plastic surgery experience and long service to Crippled Children Branch before Board plastic surgeons were available, continues with some plastic surgery.

Exceptions made are the following:

1. Statewide, at family's request, a family physician may do a pre-operative examination for a child over three years.

2. Follow-up visits for surgical cases operated in Neighbor Island hospitals at the request of operating specialist.

3. Statewide, wax removal or T&A, if recommended by otologist as an isolated procedure, may be done by family physician.

4. Follow-up conservative treatment for ear infections in children seen by otologist in clinics on Molokai and Lanai where specialty care is not available.

Occasionally there are cases which urgently need specialized surgery which is not available in Hawaii. If two consultants agree regarding the gravity of the situation and also that a favorable outcome is more probable in certain Mainland medical centers, program will pay costs including transportation for parent and child. The nearest medical center which can provide the care must be selected.

The psychologists working in the program have doctor's or master's degrees in clinical psychology.

Payments for hospital care utilized in the Crippled Children's program will not be in excess of the reasonable costs computed in accordance with methods established by the Children's Bureau.

Participating hospitals, nursing homes and care homes are licensed by the Hospital and Medical Facilities Branch and are required to meet standards set up by the Department of Health. Periodic inspection and consultation is carried out by that agency.

1. Diagnostic and treatment services are offered to children between the ages of 0-21 years on all islands unless otherwise specified.

2. Children with crippling conditions are brought to the attention of the Branch through the efforts of district health officers, public health nurses, private physicians,

hospital nurses, out-patient clinics at local hospitals, school health services, nursery schools, welfare agencies, the Division of Vocational Rehabilitation and voluntary agencies.

3. Whenever possible the services, funds and staffs of voluntary agencies are utilized.

4. Diagnostic services are available within the areas served by each diagnostic center to any child (a) without charge; (b) without restriction or requirement as to the economic status of such child's family or relatives or their legal residence; and (c) referrals are accepted from parents, agencies, physicians, hospitals, public health nurses, etc.

5. Treatment services are preceded by a means test. A child may receive total or partial assistance.

6. Local health administration: All portions of the Crippled Children's Plan are directly administered by the official State agency. The Branch delegates to districts, case finding, arranging clinics, providing information for the financial test, and the interpreting and following up on medical care recommended by the Branch.

7. The relationship with the Public Health Nursing Branch, the Waimano Training School and Hospital Division and the Mental Health Division is maintained by conferences.

8. Mental Health: The Branch refers emotionally disturbed children to the Mental Health Division for diagnostic and treatment services. Individual Guidance Center staff in turn determines appropriateness of referral. The pediatric psychiatrist from the Branch is available one half day per week for consultative services.

9. The Health Education Office provides supporting services to the Crippled Children Branch. A health educator (part-time) is assigned to the Children's Health Services Division and is available to the Branch. Her general services include interpretation of programs to the community, planning and development of specific educational projects, selection and preparation of educational materials, development of casefinding methods, assistance in group education, and aid in planning and development of in-service education programs.

In addition to the health educator, an illustrator-photographer and a printer are available to assist in the preparation of educational materials and exhibits. Film library services are also provided by the Health Education Office. As part of this service, a large number of films on mental retardation, crippling conditions, and rehabilitation are maintained and circulated to professional and lay groups in the community. The health educator selects, obtains and arranges previews of new films, but the Health Education Office does not provide funds for their purchases. Cost of educational materials for the Crippled Children and community mental retardation programs must be provided for in the Branch budget.

The bi-monthly Hawaii Health Messenger and the annual report, both of which are prepared by the Health Education Office, are official Department publications which inform the community of programs goals, changes in services, etc.

Specific Branch activities about which additional community education is needed include speech and hearing services, and the extension of Crippled Children's services to Guam and the Trust Territory. There is also opportunity for considerably more education aimed at the prevention of specific crippling conditions. An important need is education for the prevention and early treatment of middle ear infections, which are responsible for a high incidence of hearing loss in low-income areas.

Another subject area toward which educational services might be directed is the prevention of emotional problems in handicapped children. There is an opportunity for the health educator to work in cooperation with the newly-appointed consultant in child psychiatry in developing parent groups for educational purposes.

10. The central laboratory provides serological, bacteriological, parasitological, toxicological, and a limited amount of routine clinical work. The bulk of the routine laboratory examinations, however, are purchased from hospital and commercial laboratories. All the above are available from the central laboratory in Honolulu, and selected examinations from Branch laboratories on Neighbor Islands.

The Laboratories Branch is also called upon to advise on procedures, techniques and use of testing materials.

11. The Tuberculosis Branch cooperates in supplying material for tuberculin testing on children, takes chest roentgenograms on children for diagnostic purposes, follows the chest condition of crippled children with tuberculosis of bones or joints who are receiving treatment under the Crippled Children's program, and sends reports to the Crippled Children Branch in regard to the progress and activity of tuberculosis chest lesions in these patients.

12. A public health nutrition consultant paid with Public Health Service funds attends all sessions of the weekly cardiac clinics held at Children's Hospital and at Queen's Hospital. Patients and/or their parents are given dietary instructions. The nutritionist participates in case conferences, and cases are referred to public health nurses with occasional home visits made for difficult cases.

    Referrals for dietary evaluations and diet instruction are made by the Crippled Children Branch or public health nurses following evaluation clinics.

    PKU cases are followed by public health nutritionists in close cooperation with the physician on the case, the social worker and the public health nurse. At present, cases being followed are one on the Island of Hawaii, one on Maui, and three members of one family in Honolulu. A movie is being assembled showing the development of the two younger members of the family. An additional hundred feet of film is planned each year.

13. The Public Health Nursing Branch provides extensive case services. The field nurse is responsible for casefinding (the largest number of referrals are made this way), arranging and managing clinics, arranging for care in physicians' offices and hospitalization, and providing financial information for eligibility. She also provides interpretation and follows up on recommendations made, and recalls services for patients who do not attend clinics or appointments. In the mental retardation evaluation program, the public health nurse functions as a member of the team and is a major resource

in case-finding and in implementation of recommendations. Ten per cent of the patients registered with the Public Health Nursing Branch are CC-MR cases, and they require 20% of the nursing time. This service is a major factor in the delivery of the services of the Crippled Children Branch to the patients.

14. The Research, Planning and Statistical Office is called upon to advise on research, or record keeping techniques as well as setting up of a register for mentally retarded children. A half-time clerk is employed with CC funds to maintain the MR register.

15. Training of residents and interns: In order to assist the residency and intern training program, certain clinics have been located at Children's Hospital and Queen's Hospital.

16. Official Agencies:

   a. The Branch renders treatment services to orthopedically handicapped and cerebral palsied children who attend classes for crippled children at Pohukaina School. This school is under the administrative direction of the Department of Education.

   An Admissions Committee for the program is comprised of educators, therapists and administrators from both the Department of Education and the Department of Health who are closely concerned with the program. This committee meets several times a year to review applications and evaluate progress of individual children.

   b. Children dropping out from or finishing high school who are in need of vocational services are referred to the Division of Vocational Rehabilitation. The Branch continues medical rehabilitation by joint agreement of these referrals until the patient reaches 21 years of age.

   c. When foster home placement is needed for a child receiving services from the Crippled Children's program, such arrangements are made by social workers of the Department of Social Services. Periodic conferences are held to discuss the child's progress and to adjust short- and long-range plans, particularly in regard to foster home placement and the child's physical and emotional needs.

d. The Plan to Provide Services to Guamanian, American Samoan and Trust Territory Children:

This plan operates to provide services to Guamanian, American Samoan and Trust Territory children and to afford Hawaii the necessary additional staff to provide the services required. Federal non-recurring funds are appropriated to Hawaii to provide services to Guamanian, American Samoan and Trust Territory crippled children. Trust Territory referrals will channel through Guam Crippled Children Services.

(1) Objective

(a) To provide comprehensive diagnostic and/or treatment services to children referred from Guam Crippled Children Services and American Samoa that are not available on Guam, Trust Territory or American Samoa (and are available on Hawaii).

(b) To facilitate fiscal, sociological, hospital- and professional-care arrangements (1) by providing added clerical and social work personnel; and (2) by making funds available for direct payment of those and related services as specified below, subject to review and restatement in the respective State Plan each two years.

(2) Duration of Grant

Because of the lack of trained physicians in several specialties and the resulting limitation of these specialized facilities on Guam, Trust Territory and American Samoa, such a project may be required for the foreseeable future. Either party should retain the prerogative to terminate this arrangement on six months' notice.

(3) Method of Operation

The Chief of the Crippled Children Branch, Hawaii Department of Health, provides the administrative supervision and medical direction for all children referred under the Crippled Children Services of Guam (Guamanian and Trust Territory) and American Samoa. This includes determination of facilities and services to be authorized in Hawaii; or when these are not optimum in Hawaii, determination and arrangement for transfer of such children to medical centers on the Mainland.

(a) Any child (0-21 years) determined eligible and referred by Crippled Children Services of Guam (Guamanian or Trust Territory) or American Samoa will be accepted for diagnostic and/or treatment services, provided such services are available in Hawaii.

(b) Services to be restricted to those outlined in the Hawaii Public Health Plan, Item II B, on program activities by diagnostic groups; namely, cleft lip and palate, cerebral palsy, rheumatic fever and rheumatic heart disease, congenital heart disease, epilepsy, orthopedic conditions, surgical eye defects, hearing, cystic fibrosis, plastic conditions requiring long-term and multiple procedures, selected neurologic and urogenital abnormalities, and mental retardation and inborn errors of metabolism causing mental retardation.

(Shriners Hospital will continue to be used as a resource for those orthopedically handicapped children under 17 years of age for whom sponsorship has been obtained locally. In these instances, Guam Crippled Children Services or American Samoa will be responsible for securing necessary sponsorship from the Shriners' organization on Guam, Trust Territory or American Samoa at the time of initial referral to Hawaii Crippled Children Services.)

B. Program Activities by Diagnostic Groups

(Items 1-12 below are available on request but are not included in their entirety within this State Plan for Facilities for the Mentally Retarded.)

1. Cleft Lip and Palate.

2. Cerebral Palsy.

3. Orthopedic Program.

4. Plastic Surgery.

5. Rheumatic Fever.

6. Congenital and Rheumatic Heart Disease.

7. Surgical Eye Program.

8. Anomalies of External Genitalia.

9. Meningomyelocele and Hydrocephalus and Other Neurosurgical Problems.

10. Hearing, Speech and Other Disorders of Communication.

11. Epilepsy.

12. Cystic Fibrosis.

13. Endocrine and Inborn Errors of Metabolism Causing Mental Retardation.

Diagnostic and treatment services for children suspected of having cretinism, phenylketonuria, etc., are provided on an individual basis. Medication and/or special dietary products are supplied. Periodic evaluations in Child Development Clinics will be provided.

14. Mental Retardation

Special Project on Mental Retardation

I. Aims of the Project

A. Comprehensive team evaluation for children who are suspected of having mental retardation and clinical re-evaluation periodically to give direction to case management, habilitation and counseling of parents.

B. A center for developmental training of young children and for diagnostic observation to be known as the Diamond Head Child Development Center.

C. Professional and public education in mental retardation to strengthen professional services and community support for needed services.

II. Duration of the Grant

Even with State funds, the magnitude of the problem will require Federal funds for the foreseeable future.

III. Location of the Project

The evaluation service will be Statewide. Clinics will be held at Diamond Head Health Center and Children's Hospital on Oahu. On Neighbor Islands these clinics are located: Kauai, in the Lihue Health Center; Maui, in the Wailuku Health Center; Molokai, in the Kaunakakai Health Center; Hawaii, in the Hilo, Kohala, Kona and Honokaa Health Centers. The Drug Clinics are held at Diamond Head Health Center in Honolulu, and at the Hilo Health Center. The Child Development Center is located on the grounds of Leahi Hospital, Oahu, in the Diamond Head Health Center.

Project personnel are located in the headquarters office of the State Health Department and the Diamond Head Health Center; State employees participating are located in district health centers on all islands.

IV. Methods of Operation

A. Evaluation Service

Child Development Clinics are staffed with a pediatrician (team leader), medical social worker, clinical psychologist, the district public health nurse, and speech and hearing therapist; and clinics are held on a regularly scheduled basis on all islands. The resident staff medical social worker in mental retardation on Neighbor Islands is the project representative. The personnel of each clinic team is constant and stable with a resident practicing pediatrician attending clinics on Maui; an itinerant pediatrician is sent to Hawaii, Kauai and Molokai. The staff psychologists and speech and hearing therapists attend clinics on Neighbor Islands. Neighbor Island clinics require three full days (two days for the pediatrician, three days for the psychologist, and two or three days for the speech and hearing therapist). Each clinic evaluates an average of eight children (five new, three re-evaluations). The four clinics on Kauai will evaluate 34 children; four on Maui will evaluate 34 children; six or seven on Hawaii will evaluate 50 children; two on Molokai will evaluate 16 children. Children from Lanai will be seen in Maui clinics. On Oahu the full clinical team is utilized with pediatrician-team leaders, staff psychologists and social workers regularly assigned. There are two weekly (90) clinics--one at Children's Hospital and one at Diamond Head Health Center. These Oahu clinics will evaluate 180 new children and re-evaluate 90 previously known children. These clinics see an average of three children (two new, one for re-evaluation), and each clinic averages four hours time for the pediatrician; one to one-and-a-half days for the psychologist. The Children's Hospital Child Development Clinic is under the direction of the Pediatrician Medical Director of the Out-Patient Department. Pediatric resident physicians participate in this Child Development Clinic.

1. Case Selection

Child Development Clinics accept referrals of children up to 21 years with priority to children under eight years of age for comprehensive evaluation when there is tentative evidence of mental retardation on the basis of intellectual functioning, motor development, adaptive behavior, etc.; referrals from public schools are accepted when academic retardation is in association with related conditions which indicate need for comprehensive evaluation. The project selects the cases to be evaluated in the Children's Hospital Child Development Clinic.

2. Case-Finding, Diagnosis, Treatment and Follow-Up Services

Clinics will receive referrals from any source (Child Health Conferences, Crippled Children's Services, physicians, families, social agencies, schools, courts, etc., and diagnostic services) will be available to any child without reference to economic status or referral source and without charge as provided in the Crippled Children's Plan. High income families are encouraged to contribute, but no coercion is used, and services are provided regardless. Evaluative processes will be used as are indicated for the particular child. These processes initially include a health and developmental assessment by the public health nurse, pediatric, social work, speech and hearing evaluation, and evaluation by a clinical psychologist. Necessary medical consultations by such specialists as otologists, neurologists, medical geneticist, ophthalmologists, etc., and roentgen and laboratory diagnostic procedures will be utilized to provide comprehensive diagnosis. Tests for inborn errors of metabolism and chromosomal studies will be done by the laboratory at Children's Hospital, for which equipment is provided by a Children's Bureau non-recurring allocation. With the provision of equipment only, the service will be purchased on a fee-for-service basis; and as full project funding develops, arrangements to maintain equitable balance of funding and income will be worked out. During the interim period, Children's Hospital will allow the Crippled Children Branch a 10% discount on all children referred there for screening, qualitative analysis and chromosomal studies. Adjustment on the discount will be made after some experience has been gained. Children from Neighbor Islands accompanied by parents will come to Honolulu for definitive studies not otherwise available. Children who need to be under close observation for behavioral or developmental diagnosis will be placed in the Diamond Head Development Center. After the completion of evaluative processes, the clinic team is joined by interested professional workers (occasionally by a referring physician) in the case conference to determine (a) the etiology of the condition and the need for genetic counseling, the extent of retardation, the psycho-social component; (b) the treatment (medical, psycho-social, training, education, etc.) and services needed to prevent, relieve or minimize the effect of mental retardation. A summary report of the clinic's findings and recommendations is made available to interested agencies and the family physician. The medical or surgical treatment needed to correct defects, handicapping conditions, to treat inborn errors of metabolism, treatment for organically driven behavior disorders will be provided by Crippled Children's services. Public health nurses will be responsible for follow-up services on medical recommendations of the clinic and for home programing of young children. Medical social service following evaluation will usually be limited to the acceptance of diagnosis and preparation of families for the follow-up treatment or the placement recommended, and to prepare the family for referral to another agency. Social workers (Oahu) will provide intensive casework counseling in selected cases in collaboration with the psychologist for a short-term period. Psychiatric consultation will be available, and social worker and psychologist may utilize individual and group work with parents to relieve the impact to mental retardation and related family stress bearing on the adjustment of the mentally retarded child.

Children will be seen periodically by the clinic during early childhood and at later developmental stages as indicated for re-evaluation, to give direction to case planning, management and the counseling of parents.

B. The Diamond Head Child Development Center

Retarded children, three to six years of age, and multiply handicapped children, three to eight years of age, who have evidence of need for developmental training, are programed in this center, and children three to ten years of age who require short-term diagnostic observation from any island.

The Diamond Head Child Development Center provides a daily program from 8:30 a.m. to 2:30 p.m. Monday through Friday, September through July for 24 children three to ten years of age who are retarded and otherwise handicapped. The central objective of this center is the personal-social-self development of the child in a group program with intensive special therapies available for intensive individualized training.

The supervisor of daily operations of the group training program (conducted by Child Training Assistants) and coordinator of the specialist services required, is the project psychologist. The center staff consists of three full time teachers (Child Training Assistants) and part time professional staff assigned to the center: a psychologist, social worker, physical therapist, occupational therapist, and speech and hearing therapist. The program pediatrician or a fee-for-service pediatrician provides pediatric evaluation and medical direction to the center. He meets at intervals with the staff in conference to discuss individual developmental progress and programing of children. The psychologist will provide close supervision to the individual intensive training.

Midmorning and afternoon refreshments will be provided. Parents or Lions' Club funds will pay the cost of hot lunches which will be delivered to the center by Leahi Hospital food service. Transportation will be provided by the project from pick-up points within the city limits.

The training will be short-term intensive. As soon as possible, a child will be prepared for transfer to a class in public school or a Hawaii Association to Help Retarded Children's center. The maximum stay will be one year except when:

1. A specific goal is in sight which would be lost.

2. Severe physical disability precludes accurate estimate of potential, and intensive therapy may be expected to provide significant benefit.

A child judged to be unable to profit significantly by further treatment will be directed to other day or residential care facilities. Counseling will be available to help parents make realistic plans.

The daily program will include educational activities designed to re-enforce self-identification and increase the child's competence in self-care, communication, social behavior and play.

Three classes are in operation. Each child will belong to a particular teacher and class for those personal-social-play experiences best provided in group. Subsequently, a child may be moved in the course of the year, to another more or less socially sophisticated group as his needs are perceived by the psychologist and supervisor. A physically separate area will be available for the intensive therapy/training of individual children which will supplement the group program. Intensive operant conditioning is used for bladder and bowel training. Gross motor activities and perceptual-motor training techniques are also provided on a group and individual basis.

The children coming to the center for short-term diagnostic observation will be placed in one of the three classes.

Parents who are interested and could benefit from group therapy will be selected by the psychologist and social worker who will conduct this parents' program at the center. The social worker will conduct casework liaison services required with families of enrolled children.

Public health nurses will provide continuing home training programing services in consultation with the center occupational therapist to insure carry-over of center training.

The speech and hearing consultant will collaborate with the center teachers in the language arts component of the curriculum as well as provide intensive help on speech to individual children.

C. Professional and Public Education

The project provides training for professional staff as indicated. Public education aimed at realistic acceptance of the problem of mental retardation and the importance of community planning will be carried on through the use of mass media and contacts with groups. Assistance will be given by the health educator who is assigned part-time to the Children's Health Services Division.

V. Participating Personnel

The project staff is covered by the merit system. The time devoted to the project will be:

The Project Director is the Chief, Crippled Children Branch. The Crippled Children Branch Chief and the Branch Pediatrician will provide the equivalent of full time. (1) Evaluation Service: Chief Psychologist, .2 time; and Staff Psychologist, .4 time; Neurology Clinic Nurse, .5 time; State Medical Social Work Consultant, .2 time; Oahu Supervising Social Worker, .5 time; three Neighbor Island Medical Social Workers, the equivalent of 2.0 time; Oahu Medical Social Workers, four full-time; Stenographers, the equivalent of three full-time; Speech and Hearing Therapist, .6 time. (2) Child Development Center: Project Psychologist, .4 time; Occupational Therapist I, .6 time; three Child Training Assistant II's (teachers), Speech and Hearing Therapist, .4 time; Psychologist, .6 time; Physical Therapist, .6 time; Medical Social Worker, full-time; Clerk-Stenographer, full-time.

JohnsHopkins University is funding the salary of one non-professional (B.A. Degree only) "psychological technician" for 1½ years of on-the-job training at the Child Development Center. He will be given immediate supervision by the staff psychologist and supervised in selected duties by the chief psychologist. His major duties will be the administration, scoring and reporting of objective psychological tests, behavior modifications with selected patients and assisting the chief psychologist and the staff psychologist in administrative and research duties as needed. As he will be testing children in Neighbor Island Child Development Conferences, travel expenses and per diem must be funded by the Crippled Children project as Johns Hopkins University has no funds for this purpose

The chief psychologist and the staff psychologist shall devote 20% of their time in research to investigate more effective techniques in the diagnosis and treatment of mentally retarded and other disadvantaged children. Such research should emphasize behavior modification techniques in problems of learning and social adjustment.

The public school department and the social agencies will be encouraged to use the evaluation service, and there will be agreements covering referral procedures.

VI. Facilities to be Used

The old out-patient department of Children's Hospital will reserve two rooms for the project staff in addition to examining rooms.

The project will purchase the clinical service of the Child Development Clinic at Children's Hospital on the basis of hours of the pediatrician, clinic nurse, stenographer and janitor; and the project will contribute the psychological, medical social work and speech and hearing services to this clinic.

Clinic facilities used will be the health centers and the Diamond Head Child Development Center, except for Children's Hospital.

Payments for consultant services to hospitals and auxiliary services are the same as those for the Crippled Children Branch, and authorizations for services are made by the Crippled Children Branch physicians. The Child Development Center is located at Leahi Hospital. The Spaulding and Bottomley Buildings provide the facility known as the Diamond Head Health Center.

VII. Training

Professional education will be an on-going part of the clinical evaluation service with case consultation provided to teachers, physicians, nurses, social workers, etc.

VIII. Method of Evaluation

A. Progress reports from public health nurses, school personnel and other sources to which patients have been referred for follow-up will be requested periodically as one means of determining the effectiveness of the evaluation services provided.

B. Case information on project children will be available for annual comparisons of characteristics of mental retardation in Hawaii: age of admission, source of referral, etiology, medical mental retardation diagnosis, associated motor and sensory impairments, measured intelligence, self-help level, religion, ethnic origin, movement (family care - institution), special services not available.

Identification of significant changes and trends in the project caseload will be used in evaluation and project planning.

Children evaluated in Child Development Clinics who need pediatric follow-up for organic behavior disturbance, which they cannot obtain elsewhere, are referred to Drug Clinic which is held at Kapahulu Health Center and is staffed by a pediatrician. This is financed by Hawaii (State) Act 213 funds.

Dental Program for Mentally Retarded Children

I. Objective

To equip mentally retarded children to be better able to attain their maximum potential in life by providing dental diagnosis, oral-health education and treatment to children receiving evaluation services under the Special Project CC-MR.

II. Duration of Grant

The program has been in operation since October, 1966. The magnitude of the problem will require Federal funds for the foreseeable future.

III. Location of Project

The dental service will be Statewide. Diamond Head Health Center (on the Leahi Hospital grounds) will be the location of the dental personnel, files and the Honolulu Dental Clinic. On Neighbor Islands, itinerant Dental Clinics will be located as follows: Molokai, Kaunakakai Health Center; Maui, Maui Memorial Hospital; Kauai, Lihue Health Center; Hawaii, Hilo Hospital.

The offices of the Special Project CC-MR Director (Crippled Children's Physician) and the Co-Director responsible for the dental program (Director of Dental Health) are located in the main headquarters of the Hawaii State Department of Health.

IV. Facilities to be Used

In Honolulu, two rooms in the Spaulding Building of the Diamond Head Health Center have been renovated and completely equipped with two chairs and dental X-ray unit, to establish the Dental Clinic. On Kauai, the new Lihue Health Center Building was opened in 1966. A dental chair (for use by dental hygienist) and room are available there. All other dental clinic equipment including a dental X-ray unit is being purchased. Maui Memorial Hospital has rooms, and a surplus dental chair is available for installation. All other dental clinic equipment including a dental X-ray unit is being purchased. On Molokai, the Kaunakakai Health Center is equipped with a dental chair (for use by a dental hygienist) and will require complete dental clinic equipment except for a dental X-ray unit.*

Children in need of hospitalization will be hospitalized in Children's Hospital or St. Francis Hospital, Honolulu.

V. Methods of Operation

A. Administration

The Director of Dental Health, Hawaii State Department of Health, will be Co-Director of the Special Project CC-MR, and this dentist will provide direction to the dental program and staff. He will determine the acceptability of treatment plans and cost estimates when dental specialist treatment is purchased on a fee-for-service basis, and will review statements prior to the issuance of payments. The Project Director (Crippled Children's Physician) will issue authorizations for care and service under the project. The Co-Director will prepare the budget in collaboration with the Public Health Administrative Assistant of the Children's Health Services Division and the annual plan for dental services to be incorporated in the Special Project CC-MR. He will recommend appointments and prepare job performance ratings of dental program personnel.

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*X-ray service on Molokai will be negotiated with a private dentist adjacent to the Health Center

The dental hygienist will assist the Co-Director in overall administrative coordination of the program.

B. Dental Clinics

The Diamond Head Health Center Dental Clinic will be the central clinic and home office base for the dental program and staff. One full-time salaried dentist, one full-time dental hygienist and two full-time clerks (typist-dental assistants) will be employed. This dentist will serve Neighbor Island clinics on an itinerant basis. He will spend 70% of the time for Oahu and 30% for Neighbor Islands, and will be available to treat children who because of the severity of retardation will be hospitalized for one or two days in Honolulu to complete treatment under anesthesia. The dental hygienist will be in charge of appointments, records and overall clinic operations; will provide some chair assistance for the dentist; will give the prophylaxis and topical application of fluoride; and will conduct health education. The two Clerk II's will provide reception services, clerical and typing services, sterilization, light maintenance and chair assistance. One will accompany the dentist to Neighbor Island clinics.

C. Selection of Cases

Patients with mental retardation up to age 18 will be accepted with priority given to younger children and those with multiple handicaps. Children initially admitted at age four to six years and the multiply handicapped will be carried to 12 years on an ongoing annual basis. Those admitted in older age groups will be reviewed annually, and ongoing treatment provided as time permits. Twenty per cent of treatment cases will require hospitalization. With increasing experience in use of heavy sedation, it is hoped that fewer children will require hospitalization in subsequent years. Ten per cent of treatment cases are expected to require specialist services.

Diagnostic dental services are available to any child within the age ranges described above governing case selection (a) without charge, (b) without restriction or requirement as to the economic status of such child's family or relatives or their legal residence, and (c) without any requirement for the referral of such child by an individual or agency.

On the first examination, each child will have the necessary X-ray pictures taken and a routine full mouth radiographic survey will be done on six years and older children. The first examination will include prophylaxis, diagnosis and treatment plan; topical application; and oral-health education for child and responsible adult. Topical application of fluoride will be applied annually and on selected cases every six months. Each child will be re-examined annually or semi-annually (high caries susceptibility cases) and will receive prophylaxis; annual bite wing X-ray pictures or repeat radiographic survey to study development, dental anomalies, root and conditions or the progress of treatment.

The clinic will teach each child and the adults responsible for his care, the scientifically demonstrated measures of prevention and control which include: correct teeth brushing; dietary control of caries and maintenance of adequate diet; topical application of fluoride, and interference with deleterious oral habits.

The Crippled Children's Services financial eligibility criteria and method for making determination will be utilized for dental treatment services. The determination of financial eligibility for treatment service will be done prior to the first contact with the dental clinic and will be available to the clinic. Families who can afford private dental care will be referred to a dentist of their choice for treatment. All other children will receive necessary dental treatment including extractions, fillings, space maintainers and restorative dentistry in the dental clinic of the island of residence, or in the case of severely retarded children (20% of the treatment caseload) will be hospitalized in Honolulu. Children whose treatment indicates need for dental specialist (orthodontist, periodontist, pedodontist, etc.) will receive specialist service in Honolulu and the Diamond Head office will arrange for the treatment needed in the Honolulu specialist's office or the hospital as needed. Before authorization is issued to dental specialist or for hospitalization, the Dentist Co-Director will approve such plan. Fees for dental specialists and hospital reimbursable rate are the same as those utilized by the Crippled Children Branch.

Hospitalization of children will be arranged with the Crippled Children's Physician, and a pediatrician of the family's choice will supervise the child's medical care while in the hospital. The dental survey, corrective and restorative care will be the responsibility of the project dentist or the dental specialist consultant.

Follow-up services between clinic visits will be done by public health nurses who will re-enforce oral health instruction, and assist families in arrangements for dental treatment.

All dental records will be filed in the Diamond Head Dental Clinic office, and reports of treatment completion will be filed in the Child Development Clinic case record. For Oahu children, a pediatric evaluation and medical treatment status report will be sent to the Diamond Head Dental Clinic; on Neighbor Islands the dentist will have the Child Development Clinic case record available in clinic.

VI. Participating Personnel

Personnel to be employed by the Project will be covered by the Merit System:

(1) Dentist, full-time (SR-25) will perform dental diagnostic and treatment services for children in the Honolulu Dental Clinic. Fee-for-service dentists for Neighbor Island clinics and for hospitalized children will hold dental degrees from accredited dental colleges and be licensed to practice in Hawaii. All dentists will be supervised by the Co-Director, the Director of Dental Health.

(1) Supervising Dental Hygienist (SR-15) will assist the Co-Director in overall administration and coordination; will provide prophylaxis, topical application and oral-health education; will be responsible for overall operation of the Diamond Head Health Center Dental Clinic, including

the supervision of the dental assistant. This hygienist will be supervised by and report to the Project Co-Director, the Director of Dental Health.

(1) Dental Assistant II (SR-8) will give chair assistance to the dentist in light maintenance and sterilization, and will accompany the dentist on Neighbor Island clinics. In addition, she will act as receptionist and will do some clerical work including typing.

Regular employees of the Health Department who will participate in the Project:

The Director of Dental Health (SR-30) who is Executive Officer of the Dental Health Division, will be Project Co-Director and direct staff and program, standards of dental services, etc. He will work closely with the Project Director, Crippled Children's Physician, in coordinating dental services within the project (15% time).

The Crippled Children's Physician, the overall Special Project CC-MR Director, will collaborate with the Co-Director in coordination of total project services and the administrative authorizations recommended by the Co-Director.

The Dental Hygiene Administrator, Dental Health Division will provide technical consultation to the project dental hygienist.

The Public Health Nutritionist, Children's Health Services Division, will provide nutrition consultation to the project dental hygienist.

The public health nurses of the Public Health Nursing Branch will conduct family liaison service for dental clinics, referring children, and do follow-up on dental treatment plans.

Supervising Public Health Nurses on Neighbor Islands will schedule children for clinic and conduct liaison communication relative to cases with the Diamond Head Health Center Dental Clinic.

VII. Admission and Discharge Policies

Reference to the Special Project CC-MR Plan. Policies, forms and payments will be identical to those utilized in the Crippled Children's Services program.

VIII. Methods of Evaluation

Statistical reports of cases by Children's Bureau age range, diagnostic and treatment categories, and services rendered will be kept by each clinic. The Diamond Head Dental Clinic monthly report and individual reports of each neighbor Island clinic will be kept.

Dental examination findings will be incorporated in the data collection system of the Dental Health Division, and information on the dental status of retarded children on the first visit to clinic will be analyzed and used in program planning. Comparisons can be made periodically between the status of new children without previous care and those receiving early and continuous preventive dentistry under the project.

III. Therapy Sections

A. Physical Therapy Unit

Physical therapy is an integral part of the health and medical care program under the Crippled Children Branch. The Plan provides for a staff of five physical therapists and one physical therapy aide. The staff jointly plans, organizes, integrates and implements the preventive, evaluation and treatment services to children prescribed by physicians.

1. Program Content

Physical therapy services are provided in the following established programs on the Island of Oahu.

a. Pohukaina School for Handicapped Children: Physical therapy is a key service since many of these children are extremely severely involved with neuromuscular and orthopedic handicaps. Some of these children are also mentally retarded. The physical therapy services emphasize the inter-disciplinary team approach in implementing the treatment program and obtaining the goals set up for maximum recovery.

b. Diamond Head Child Development Center: A physical therapist is assigned to this center three days per week, providing evaluation and therapy as needed for the 24 children in the center, the children in the United Cerebral Palsy class who are known to the Branch, and selected other Crippled Children Branch children on an out-patient basis.

c. Home Program: This program provides for regular direct treatment services to very young children, severely involved children, and children living in the rural community. For those children who only require supervisory and instructional services, there is an ongoing evaluation and instructive home program with public health nurses.

d. Summer Program: Approximately 25 children receive direct physical therapy treatment services in the joint program with the Department of Education.

e. Island of Hawaii: Itinerant physical therapy services are rendered on a regular four days per month basis in rural Hawaii.

B. Occupational Therapy Unit

Occupational therapy is used in preventive, diagnostic and rehabilitative aspects of the program. Evaluation, direct treatment and consultation are offered.

1. Pohukaina Orthopedic Unit

Occupational therapy services are geared primarily for the young handicapped child with orthopedic, neuromuscular and/or perceptual-motor dysfunction to help him gain functional, sensori-motor and self-care skills. Consultation is provided to classroom teachers and parents to establish carry-over practice and maintenance of the attained activities of daily living in the classroom and home.

2. Diamond Head Child Development Center

At this center, occupational therapy plays an integral part in the diagnostic and training program for the young severely mentally retarded or multiply handicapped preschool child. Primary objectives in therapy are sensory training, sensori-motor integration, and self-help skills. Consultative services for classroom and home carry-over are given the child training assistants and parents.

3. Child Training Centers

The occupational therapy consultant provides consultation on request to the Oahu centers, and makes annual visitation plans to the Neighbor Island centers for a continuing staff development program and to assist the classroom personnel in teaching methods and center operations. An annual two- to three-day Statewide teachers' conference is planned jointly with the Hawaii Association to Help Retarded Children for the purpose of discussing current trends and new techniques in the training of the mentally retarded and the multiply handicapped child.

C. Speech and Hearing Unit

In addition to the activities described under "Hearing Conservation", and MR Special Project, the speech therapists are involved in a wide range of diagnostic and treatment activities. Children with cleft lip and palate and children with cerebral palsy are given speech and hearing evaluations. There is an increased awareness in the community of the value of early diagnosis, and private physicians are referring an ever increasing number of young children with disorders of communication.

Speech therapy is available to all children who require this service at Pohukaina School. Therapy is also available to selected school-age and preschool-age children on an out-patient basis at the Diamond Head Child Development Center.

Two speech therapists participate in the six-week summer program at Pohukaina School.

Services to Neighbor Islands are consultative and evaluative. Services to Sultan School, Kahala Evaluation Center and Diamond Head School are also consultative and evaluative.

D. Medical Social Services Unit

Medical social services are provided by the medical social work staff wherever and whenever indicated. The functions of the medical social work include: social casework, consultation, community planning, program planning and educational activities. The casework staff is assigned patients attending the various clinics. Medical social services are provided to selected crippled children attending Sultan and Pohukaina Schools for the Handicapped.

The lack of sufficient social work personnel has prevented the giving of adequate social services to a larger proportion of the children serviced, particularly on the Neighbor Islands where the staff of the MR Special Project serving MR children are as yet only to accept a very few physically handicapped children.

The Children's Health Services Division medical social work consultant participates in case reviews on the Neighbor Islands with the Crippled Children's Physician.

Staff Development: Regular monthly staff meetings will continue with emphasis placed upon program planning, review of policies and procedures, inter-agency agreements, professional development, and in-service training. Conferences are held between the medical social service consultant and the social work staff in the Crippled Children Branch. Periodically there is medical and/or psychiatric consultation for teaching and training purposes.

Participation in Field Work Program: The Branch cooperates with the University of Hawaii School of Social Work in the training of students.

E. Psychological Unit

The chief psychologist of the Children's Health Services Division functions also as head of the psychological unit (Crippled Children Branch). He is assisted by one psychologist in the MR Special Project. Most of the diagnostic and intensive counseling services are used in the Special Project, and in addition a few evaluations are purchased by fee-for-service or arranged (on Neighbor Islands) with the Mental Health Division.

To relieve the shortage of clinical psychologists, the Branch has a training project with the John Hopkins Hospital in which a trainee (with a college or equivalent education) will be trained for a period of one and one-half years by the chief psychologist. The salary and general expenses for the one trainee will be paid directly by John Hopkins University. Such a technician, after he is fully trained, could be used in the program to assist a qualified psychologist.

F. Administrative Unit

The public health administrative assistant of the Children's Health Services Division continues to be responsible for the non-medical administrative functions of the Crippled Children Branch. He works closely with the Chief in carrying out the activities of the Branch.

A major task in the 1967-1968 fiscal year will be revision of payment procedures to conform to newer Federal regulations.

IV. Children's Bureau Regulations - Descriptive Material

200.2 (b) (1) Legal Bases for Plan

Legal bases - Chapter 46, Section 46-40, Revised Laws of Hawaii, 1955.

It is hereby declared to be the public policy of the State to develop, extend and improve, especially in rural areas, services for locating children who are crippled or who are suffering from conditions which lead to crippling and to provide for medical, surgical, corrective and other services, and care and facilities for diagnosis, hospitalization and aftercare for such children.

200.6 Methods Used to Make Information About Services Generally Available to the Public

Information shall be made freely available to the public by the following methods:

By press releases to major newspapers in Hawaii when significant information develops, such as numerical extent of crippled children prevalence in Hawaii, maternal and infant mortality rates, announcements of institutes, lecture courses, visiting authorities, calls for blood donor, etc.

By general distribution of the Branch's annual report and statistics as part of the departmental report to physicians and professional groups in Hawaii and to state agencies on the Mainland.

By provision of health columnists with up-to-date information and data on maternal and infant care.

In all our contacts with other agencies and the lay public, we take the opportunity of indicating extent and availability of services for crippled children and interpreting the regulations relating to provision of these services.

Showing of movies, exhibits, radio talks, lectures and television spots and films.

200.12 (b) Confidential Information

The Department of Health has issued a directive in respect to the disclosure of information about children under care of the Children's Health Services Division.

A. Disclosure of confidential information is prohibited by all employees of the Division. Furthermore, no information obtained by any representative or employee of the Division in the course of discharging duties shall be disclosed, directly or indirectly, other than in the administration of the program.

B. Disclosure of confidential information concerning a patient shall be released:

1. Only for purposes directly connected with the administration of Maternal and Child Health and Crippled Children programs or after obtaining, either expressly or by necessary implication, the consent of the patient to such disclosure. Request by patient for release of confidential information must be made in writing.

2. To other welfare agencies only after such welfare agencies or programs give adequate assurance that:

a. Confidential character of information will be preserved.

b. Confidential information will be used only for the purpose for which it is made available.

c. Confidential information will be made available when related to the Children's Health Services Division.

d. The standards of protection established by the inquiring agencies or programs are equal to those established by the Children's Health Services Division itself.

3. When any member of the Children's Health Services Division or members of the State Health Department receives or accepts service of a subpoena ordering him to produce references in violation of the policy on confidentiality of case records, this provides an exception for the release of confidential information.

C. Disclosure of confidential information is authorized by the Executive Officer of the Children's Health Services Division or his designated agent.

D. Documents and records of Crippled Children Branch shall be accessible only to the Department's personnel. No documents or records shall be taken from the office except for use in the Branch's procedures. Care is taken to see that these records and documents are properly safeguarded at time when offices are officially closed.

E. The Chief of the Branch may release to the public for useful purposes, reports and statistics dealing with any or all phases of the Crippled Children Branch, provided that individual cases cannot be identified from these reports.

200.13 (a) Methods Utilized in Establishing and Substantiating that Rates of Payment for Medical Care, Appliances, and Convalescent and Aftercare are Reasonable and Necessary to Maintain the Standards Relating to the Provision of Services in the Plan.

The methods utilized in establishing and substantiating that rates of payment for medical care, appliances, and convalescent and aftercare are reasonable include:

Compliance with Children's Bureau regulation.

Negotiation with the parties concerned and taking the lowest of those bids submitted as the criteria.

Should not be higher but may be lower in comparison with existing local rates for similar services.

Recommendations by an advisory group or its sub-committee such as the Dental, Orthodontic or Medical Association.

A BILL FOR AN ACT

RELATING TO PHENYLKETONURIA TESTING

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF HAWAII:

SECTION 1. Declaration of purpose. The purpose of this Act is to establish a systematic method of detecting and combating a genetic defect causing phenylketonuria. This condition commonly known as PKU is the result of an inborn error of metabolism and usually produces such severe and irreversible brain damage in young children that life-long institutionalization is required. If found and treated within the first two weeks of life, mental retardation is prevented.

SECTION 2. Chapter 46, Revised Laws of Hawaii 1955, as amended, is hereby further amended by adding thereto a new section to be appropriately designated, and to read as follows:

> "§ 46- ___. Test for phenylketonuria. The physician, midwife, or other person attending a newborn child shall cause a phenylketonuria test to be administered to the child; provided, that this section shall not apply if the parents, guardian or other person having the custody or control of such child objects thereto on the grounds that such test conflicts with their religious tenets and practices.
>
> "The department of health shall adopt rules and regulations to carry out the purposes and provisions of this section, including, but not limited to, administration of phenylketonuria tests, keeping of records and related data, and reporting of positive test results."

SECTION 3. This Act shall take effect upon its approval.

APPROVED this 4th day of May, 1965.

'signed' John A. Burns

GOVERNOR OF THE STATE OF HAWAII

PUBLIC HEALTH REGULATIONS

Department of Health, State of Hawaii

Chapter 36

TESTING OF NEWBORN INFANTS FOR HEREDITARY METABOLIC DISEASE

Under and by virtue of the provisions of Chapter 46, Revised Laws of Hawaii 1955 as amended, and Act 19 of the Session Laws of 1965, and all other applicable laws, the rules and regulations of the Department of Health of the State of Hawaii are hereby amended to include a chapter to be numbered Chapter 36, and to read as follows:

PREAMBLE

Whereas, a number of hereditary metabolic diseases including, but not limited to phenylketonuria (commonly referred to as PKU), produce irreversible brain damage resulting in severe mental retardation as well as other human wastage; and

Whereas, mental retardation and such other human wastage from said hereditary metabolic diseases can be prevented if such diseases are detected and treated early in infancy; and

Whereas, because most infants are born in hospitals where appropriate screening procedures can be readily instituted for detecting one or more of these hereditary metabolic diseases;

Now therefore, it is hereby declared to be the public policy of the State Department of Health to cause appropriate screening, diagnostic and treatment control tests to be administered; to establish and maintain a registry of known and presumptive cases in order to facilitate follow-up services to prevent mental retardation resulting from metabolic diseases; and to cooperate, where necessary or desirable, with attending physicians in providing for the continued medical care, dietary and other related needs of children afflicted with hereditary metabolic diseases.

SECTION 1. SCOPE

The provisions of this chapter shall be the minimum requirements, adopted for the purpose of detecting the metabolic diseases hereinafter specified in order that early specific treatment may be instituted and thereby prevent the development of certain types of mental retardation and associated disorders in children resulting from genetic defects.

SECTION 2. DEFINITIONS

a. Approved - conformity to standard methods or procedures adopted or authorized by the State Department of Health, hereinafter referred to as the "Department".

b. Diagnostic Test - application of specific test methods relative to an individual patient for the purpose of verifying or confirming positive results of screening tests.

c. Hereditary Metabolic Disease Register - a continuing roster of the names of individuals, maintained by the Department, having diagnosed or suspected types of hereditary metabolic diseases, and such other information and data as is necessary to carry out the purpose and provisions in this Chapter.

d. Phenylalanine - an amino acid essential in human nutrition.

e. Phenylketonuria (hereinafter referred to as PKU) - a hereditary metabolic disease which usually leads to severe degrees of mental retardation and is caused by inability to metabolize in a normal way, phenylalanine, an amino acid essential to growth and tissue maintenance. As a consequence, the ingestion of phenylalanine normally present in milk, and other foods, results in an accumulation of phenylalanine in body fluids and tissues and the subsequent excretion of increased amounts of phenylpyruvic acid in the urine. Continued metabolic imbalance during infancy produces irreversible damage to the central nervous system. At birth, an affected infant appears normal and has a low blood plasma level of phenylalanine. Early treatment greatly lessens or eliminates brain damage and permits normal mental development. Early casefinding in the newborn period is essential in order to institute highly successful low phenylalanine dietary therapy.

f. Phenylpyruvic acid - a product of the metabolic breakdown of phenylalanine appearing in the urnie of PKU patients, in abnormal amounts after several weeks of age.

g. Screening test - a test, examination or other procedure, including the laboratory testing of a specimen or stated series of specimens, of body fluids, which testing is applied to groups or classes of individuals as a casefinding method for discovering presumptive disease or defect.

SECTION 3. TESTS REQUIRED

a. The physician, midwife or other person attending a newborn child after birth shall cause such newborn child to be subjected to appropriate screening tests, approved by the Department, which are designed to detect specific metabolic diseases.

b. Exceptions. No such tests shall be administered to any child whose parents, guardian or other person having custody or control of such child, objects in writing thereto, on the grounds that such tests conflict with their religious tenets and practices.

SECTION 4. RECORD OF TEST: REPORTS

a. The physician, midwife or other person who has caused a newborn child to be subjected to a screening test required by this Chapter shall be responsible for the recording of such testing.

b. In the event that written objection is made to such testing, the physician, midwife or other person attending the newborn child shall be responsible for recording such statement and shall report the name of said child, in writing, to the Hereditary Metabolic Disease Register.

c. Each laboratory in which positive or presumptively positive screening or diagnostic test results are obtained, indicative of any of the diseases mentioned in this chapter, shall promptly report such test results to the Hereditary Metabolic Disease Register, in the form prescribed by the Department. The physician, midwife, or other person responsible for recording the screening test shall be promptly notified by the Department of such positive test result.

d. Any physician who shall diagnose any of the conditions mentioned in this chapter, whether or not the person afflicted is under continuing observation or treatment, shall report the name of such person to the Hereditary Metabolic Disease Register.

SECTION 5. HEREDITARY METABOLIC DISEASE REGISTER

There shall be established in the Department a permanent register known as the Hereditary Metabolic Disease Register in which will be maintained and recorded the following information:

a. Every positive or presumptively positive test indicating the presence of any of the conditions specified in this chapter; the name of the individual afflicted, the name of the physician, midwife or other person attending such individual and any confirmed diagnosis thereof.

b. The names of those individuals to whom a screening test was not administered because of religious objections.

c. Such other information and data as the Department may deem necessary relative to the medical progress of the individuals specified in (a) and (b) above.

SECTION 6. FOLLOW-UP OF PATIENTS

All positive or presumptively positive test results and all reported cases of conditions specified in this chapter shall be followed up by the Department in cooperation with the attending physician. In cooperation with the attending physician, the services and facilities of the Department, may be made available to assist in the continued medical care, dietary and other related needs of children afflicted or suspected of being afflicted, when the families of such children are financially unable to meet these needs.

SECTION 7* PHENYLKETONURIA, SCREENING PROCEDURES FOR

a. Approval of procedures and laboratories. For the purpose of detecting elevated levels of blood phenylalanine, and hence to serve as a case finding procedure for phenylketonuria, screening procedure shall be carried out and administered by blood testing all newborn infants. The method of collecting the blood sample and the test procedure used shall be as approved by the Department. All blood samples for screening or for quantitative diagnostic phenylalanine determination shall be tested in the Department Laboratory, or in a laboratory approved in writing by the Department for that purpose.

b. Blood sampling procedures for all newborn infants. A screening blood sample for phenylalanine determination shall be collected just prior to discharge from the hospital, if the infant has been on milk feeding for a minimum of 24 hours. If not, the responsible physician, midwife or other person shall cause the screening test to be done within fourteen (14) days of birth, and transmit each test sample to the laboratory.

c. Relatives of known PKU cases. In addition to the screening blood sample collected just prior to discharge from the hospital, the names of newborns who are siblings of known PKU cases shall be reported to the Hereditary Metabolic Disease Register.

d. Positive: presumptive positive tests: Notification. Any screening blood test result revealing 4 mg/100 ml. or more, of phenylalanine shall be considered "positive" and presumptive for PKU, and shall be immediately reported with sufficient identifying information to the Hereditary Metabolic Disease Register. The Hereditary Metabolic Disease Register shall promptly contact the attending physician and shall require another blood sample to be secured from the infant for retesting for determination of quantitative levels of phenylalanine. Infants continuing to exhibit blood test results showing significantly elevated phenylalanine levels shall be subjected by the attending physician without delay to essential tests and clinical evaluations in order to confirm or eliminate a diagnosis of PKU.

e. Confirmatory tests. No final diagnosis of PKU shall be established unless there is recorded, in addition to a positive screening test, at least one significantly elevated quantitative blood phenylalanine test result coupled with a complete clinical evaluation.

SECTION 8. PENALTY

Any person violating any of the provisions of this chapter shall be guilty of a misdemeanor and upon conviction thereof shall be punished by a fine not exceeding five hundred dollars ($500), or by imprisonment not exceeding one year, or by both such fine and imprisonment.

SECTION 9. SEVERABILITY CLAUSE

Should any section, paragraph, clause, phrase or application of this chapter be declared unconstitutional or invalid for any reason, the remainder of said chapter, or the application thereof, shall not be affected thereby.

I, Leo Bernstein, M.D., Director of Health, hereby certify that the foregoing regulations were adopted by the Department of Health on the 21st day of January, 1966.

LEO BERNSTEIN, M.D.
Director of Health

The foregoing regulations are hereby approved as to form this 11th day of February, 1966.

CLINTON K. L. CHING
Deputy Attorney General

BERT T. KOBAYASHI
Attorney General

The foregoing regulations are hereby approved this 19th day of February, 1966.

JOHN A. BURNS
Governor of Hawaii

*Amendments to Section 7, as approved by the Governor on July 1, 1966 have been incorporated into the printing of these regulations.

WAIMANO TRAINING SCHOOL AND HOSPITAL

General Introduction

The objective of the Waimano Training School and Hospital is to plan for and provide comprehensive institutional services for the retarded and provide for post-institutional placement and supervision. Coordination of these services with those of other governmental departments and voluntary agencies is stressed.

Significant Administrative and Health Needs

a. Completion of data transfer to the Central Register.

b. The continuation of professional education and staff in-service training.

c. The completion of a capital improvement program to eliminate the last non-fireproof facility.

d. Employment of sufficient staff at Waimano Training School and Hospital to take care of the severely retarded increasing in number.

e. Placement of children and severely retarded adults in the community.

f. The establishment of investigative programs and demonstration programs to develop, hold, and obtain staff as well as to contribute to the quality of services rendered.

g. Regular preventive health services including dental care for wards in post-institutional placement.

h. Improve the safety and sanitation factors in the food service through adequate staffing.

Direction of Program Development

1. Development of on-the-job training programs at Waimano Training School and Hospital for retarded adolescents living in the community and a sheltered workshop with the collaboration of the Vocational Rehabilitation Division.

2. Strengthen the auxiliary and the religious programs.

3. Streamline housekeeping functions and secure a paid staff to run the institution.

4. The development of small semi-autonomous units to improve patient care; addition of professional staff to meet the needs of the rehabilitation program.

5. Employment of retardates who cannot compete in the open labor market.

Program Content

1. Medical and Hospital Branch:

   In addition to providing medical care for all the patients, this Branch provides nursing care for the seriously multiply handicapped and provides infirmary services for ambulatory residents. It staffs the dispensaries and provides laboratory, psychological and physical therapy services.

2. Training Branch:

   This Branch provides occupational therapy services, training and education of patients in play school activities, trainable, educable, home craft and recreational programs. This Branch is responsible for orientation of new employees; provides in-service training for Mental Retardation Attendants in the Hospital In-Service Training Program; directs the pre-community placement programs and special units for children of school age.

3. Social Services and Placement Branch:

   This Branch provides social casework services to institution residents and selects, evaluates, places, and supervises residents living in the community; including home and job placement, guardianship responsibilities and control of finances.

   Collaborates with the School of Social Work, University of Hawaii, to provide the clinical field for six to eight students in the medical sequence.

4. Institution Facilities Branch

   This Branch provides administrative functions for the institution as well as the services for the day-to-day operation. These are business services, laundry services, maintenance and production services, sewing services and food services.

5. Cottage Life Branch

This Branch provides supervision of residents in their work projects and in their cottage or dormitory living.

6. Hospital Improvement Program

The purpose of the Hospital Improvement Program is to provide intensive treatment, care and training to the residents of two units.

7. Language Disorder and Language Disability Projects

In the community, clinical services are offered to children and adults suspected of learning disabilities and to preschool children with suspected language disorders.

Participating Agencies

1. The Health Education Office assists with professional training and public information programs.
2. The Mental Health Division provides a psychiatric clinic at Waimano Training School and Hospital.
3. The Hospital and Medical Facilities Branch assists with nursing policies, procedures, and in-service training for nursing personnel. It also assists in the establishment and certification of nursing homes and care homes and in the setting of policies and standards for these facilities.
4. The Laboratories Branch assists with the bacteriologic work at the institution; the Tuberculosis unit conducts case finding programs at the institution; the Environmental Health Division gives consultation on sanitation problems at the institution and provides in-service staff training. The Nutrition Branch conducts studies of food service management and provides consultation on diet and nutrition.
5. The Research, Statistics and Planning Office, Administrative Services Office and Personnel Office give services to the Division in their respective areas.
6. The Dental Health Division provides dental services at the institution.

7. The Attorney General's Office assists with legal problems. Accounting and General Services (Department of Public Works) assists with capital improvements at the institution.

8. The Vocational Rehabilitation Division and the Department of Social Services are involved in vocational training of residents and provision of funds required for subsidization of community living facilities.